

SUBCHAPTER E. Health Facility Fees
28 TAC §§ 134.403 and 134.404

1. **INTRODUCTION.** The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance (Department). Division of Workers' Compensation (Division), adopts new §134.403 concerning Hospital Facility Fee Guideline – Outpatient and new §134.404 concerning Hospital Fee Facility Guideline - Inpatient. The new sections are adopted with changes to the proposed text as published in the October 12, 2007, issue of the Texas Register (32 TexReg 7214) and error corrections published in the November 2, 2007, issue of the Texas Register (32 TexReg 8015 and 8016).

2. **REASONED JUSTIFICATION.** These new sections are necessary to comply with the requirements of Labor Code §413.011, which requires the commissioner to adopt fee guidelines that are fair and reasonable, designed to ensure the quality of medical care, and achieve effective medical cost control and Labor Code §413.012, which directs the commissioner to review and revise the fee guidelines every two years to reflect fair and reasonable fees.

In developing fee guidelines, Labor Code §413.011 requires the commissioner to adopt health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems, using the most current methodologies, models, values, or weights used by the Centers for Medicare and Medicaid Services (CMS) in order

to achieve standardization. Additionally, Labor Code §413.011 requires the commissioner to develop one or more conversion factors or other payment adjustment factors in determining appropriate fees, taking into account economic indicators in health care. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf, and may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by CMS. Labor Code §413.012 requires a review of medical policies and guidelines every two years to reflect both fair and reasonable fees, and reasonable or necessary medical treatment. Labor Code §413.0511 requires the Medical Advisor to review the fee guideline rules and make recommendations, that are consistent with §413.011. These provisions are considered as the rules are developed.

There is currently no fee guideline that addresses outpatient hospital services. Instead, hospital outpatient services are currently reimbursed on a fair and reasonable basis, as provided by §134.1 of this title (relating to Medical Reimbursement). Adopted new §134.403 provides an outpatient hospital fee guideline, which uses the Medicare system as a framework for the billing and reimbursement methodology and establishes standardized formats used in the group health and Medicare systems.

Reimbursements for acute care inpatient hospital services are currently established by §134.401 of this title (relating to Acute Care Inpatient Hospital Fee Guideline), effective August 1, 1997. Section 134.401 provides instruction for calculating reimbursement amounts for health care provided in acute care inpatient hospitals to injured employees in Texas. The reimbursement amounts in § 134.401 provide different methods of reimbursement based on the specific classification of the hospital and the type of services and total charges related to the admission. These methodologies include per diem reimbursement, stop-loss reimbursement, and when required, fair and reasonable reimbursement as initially determined by the carrier. New §134.404 is necessary because current §134.401 was adopted prior to significant statutory changes enacted in 2001 by HB 2600, 76th Legislative Session. HB 2600 amended Labor Code §413.011, creating the requirement that fee guidelines be based on current Medicare reimbursement methodologies. New §134.404 provides a new inpatient hospital fee guideline that applies reimbursement methodologies that reflect current Medicare prospective payment practices, including a Medicare-based outlier methodology to replace the previous charge-based stop-loss methodology. The structure set out in new §134.403 and §134.404 uses the Medicare system as a framework for the billing and reimbursement methodology and establishes fee guidelines that use standardized formats used in the group health and Medicare systems.

MEDICARE

CMS regulates the Medicare and Medicaid programs. CMS has established a Medicare prospective payment system (PPS) for hospital/facility-based services, which include inpatient and outpatient hospital care, ambulatory surgical services, and other facility-based services such as, but not limited to, rehabilitation, psychiatric, and long term care units. Medicare requires a deductible and co-pay from the patient, until the patient reaches a certain level of expenditures. When setting reimbursement amounts, Medicare considers and includes this deductible and co-pay for facility services. CMS has directed an enormous amount of research into determining facility reimbursements in the Medicare System. Reimbursements are based on a facility's expected cost to provide a service rather than charged amounts, thus reimbursements differ by facility type. CMS establishes a predetermined amount of reimbursement which bundles or packages services; therefore, financial risk is assumed by the health care facility, which encourages efficient delivery of care. CMS updates reimbursements periodically based on a variety of factors, including weights (e.g., intensity), clinical issues, costs, inflation, and federal budget constraints. Reimbursement is based on national average costs with adjustments for geographic and facility specific factors. In addition, billed claims are subject to clinical coding edits Medicare has developed.

Diagnosis Related Groups (DRGs) were adopted by CMS (at that time named the "Health Care Financing Administration") in the early 1980s for the reimbursement of hospital inpatient services, and this methodology is widely used by other payors. DRG groups are based on clinically similar diagnoses requiring similar amounts of resources. Each inpatient stay is grouped into a single DRG, and each stay is reimbursed at a predetermined per discharge rate for the DRG, regardless of billed amount or length of inpatient stay, though CMS makes adjustments called "outliers" to the reimbursement to reflect extraordinarily high cost cases. To determine outliers, the base payment rates are multiplied by individual DRG weights and adjusted for local market conditions, or geographic adjustments. Adjustments for local market conditions are accomplished through the wage index, the capital geographic adjustment factor, and the large urban add-on. The operating and capital payment rates are increased for facilities that operate an approved resident training program, and for facilities that treat a disproportionate share of low-income patients. For some transfer cases, rates are reduced; and for extraordinarily costly cases, outlier payments are added. Separate Medicare payments, unrelated to payment for individual discharges, are made for Direct Graduate Medical Education expenses and Medicare bad debts. In addition, a separate reimbursement is allowed for new technology. Rural and other defined hospitals are exempt from payments

under the Inpatient Prospective Payment System (IPPS) and have special payment provisions.

In setting the payment rates in the Outpatient Payment Prospective System (OPPS), CMS covers hospitals' operating and capital costs for the services they furnish. Ambulatory Payment Classifications (APCs) were adopted by CMS in August 2000, and the APC methodology is not as widely used by other payors. There are more than 808 APCs based on clinically similar items and services requiring similar amounts of resources. An outpatient visit may include multiple APCs, each APC having a predetermined rate. CMS determines the payment rate for each service by multiplying the APC relative weight for the service by a conversion factor. The relative weight for an APC measures the resource requirements of the service and is based on the median cost of services in that APC. CMS makes outlier adjustments to reflect unusually high cost cases. Additional payments to the facility are made for pass-through items based on hospital specific cost information (e.g., drugs and implantables). Some outpatient services (e.g., physical therapy, occupational therapy, durable medical equipment, laboratory) are reimbursed using the Medicare physician fee schedules rather than being grouped into an APC.

One exception to CMS's method for setting payment rates is the new technology APCs. CMS assigns services to new technology APCs on the basis of cost information collected from applications for new technology status. New

technology APCs encompass cost ranges from \$0-\$10 to \$9,500-\$10,000. CMS sets the payment rate for a new technology APC at the midpoint of its cost range.

Hospitals can also receive three payments in addition to the standard OPPS payments: (1) pass-through payments for new technologies; (2) outlier payments for unusually costly services; and (3) hold-harmless payments for cancer and children's hospitals and rural hospitals with 100 or fewer beds that are not sole community hospitals.

USE AND COLLECTION OF DATA

Division Data

In maintaining a medical billing database, the Division requires carriers to submit billing and reimbursement information to the Division on a regular basis. The Division implemented a new reporting format in late 2006 to facilitate collection of medical billing and reimbursement data from carriers in conjunction with new electronic billing reporting requirements. The new electronic reporting format is the International Association of Industrial Accident Boards and Commission's (IAIABC) 837 format. Carriers submitted calendar year (CY) 2005 charged and paid data in this new format and the Division has based the primary components of its analysis on CY 2005 information. When the data was made available for use, CY 2005 data was determined to be the most complete set of mature claims data available. The Division prepared a series of reports to have

an improved understanding of the types of hospital inpatient and outpatient services provided to injured employees and to understand the billing and reimbursement calculations associated with those services. The Division was also able to review charge and payment activity for specific types of admissions. These admissions were further organized to focus on hospital measures followed by carriers' measures. These measures include trauma admissions, burn admissions, surgical admissions, and charges and payments for "carve-outs," including implanted surgical devices. Additionally, the Division's CY 2005 data showed similarities with comparable Texas Health Care Information Collection/Center for Health Statistics data for CY 2005, as described in the following sections.

Hospital services account for a significant portion of the medical benefits paid in the Texas workers' compensation system. Payments to hospitals for CY 2005 services totaled approximately \$205 million, which represents approximately 20 percent of total medical payments. These payments were split relatively evenly between inpatient services (\$93 million) and outpatient services (\$111 million).

Although inpatient services account for a significant portion of hospital reimbursement, there were less than 10,000 inpatient discharges reported with services provided by 578 hospitals in CY 2005. A little more than a third of the inpatient admissions were made to 23 hospitals that each had more than 100

admissions. On the other end of the spectrum, 411 hospitals had ten or fewer Texas workers' compensation admissions in CY 2005. Hospitals with more than 100 admissions were responsible for 47 percent of inpatient charges and 45 percent of inpatient reimbursements.

Texas Health Care Information Collection/Center for Health Statistics (THCIC)

The THCIC is an entity within the Texas Department of State Health Services, and is governed under the rules and regulations of the State Health and Safety Code. The THCIC develops a statewide health care data collection system to collect health care charges, utilization data, provider quality data, and outcome data to facilitate the promotion and accessibility of cost-effective, quality health care. THCIC data does not build on and does not duplicate other data collection required by state or federal law, by an accreditation organization, or by board rule, and the center works with appropriate agencies to review public health data collection programs in Texas and recommend, where appropriate, consolidation of the programs and any legislation necessary to effect the consolidation. Additionally, THCIC is designed to assure that public use data is made available and accessible to interested persons with defined processes for providers to submit data.

The Division obtained public use data sets from THCIC for CYs 2003, 2004, and 2005. The data includes detailed information regarding every inpatient discharge in Texas. Specific identifiers for low volume providers are summarized

to protect patient confidentiality. The Division developed numerous queries of the data, and provided summary analysis to the Data Methodology Committee, a committee described later in this preamble. For example, the following queries were run from the data:

- * All workers' compensation discharges for 2004 and 2005;
- * Top 25 workers' compensation DRGs for 2004 and 2005;
- * All discharge by quarter for the top 5 DRG codes;
- * Average dollar amount of charges by quarter for the top 5 DRG codes;
- * All discharges for the top 25 Texas workers' compensation DRGs for 2004 and 2005; and
- * Average dollar amount of charges, average length of stay by payor type.

The data was further segregated by discharges to separately identify trauma codes, discharges with billed charges less than \$40,000, and discharges with billed charges more than \$40,000. Additionally, further extractions were made to identify the estimated impact based on revenue codes of "carve-out" payments made under current §134.401.

Milliman Consultants and Actuaries

In July 2007, the Division entered into a professional services agreement with Milliman, a leading consultant to the health insurance and health

maintenance organization (HMO) industries. Specifically the agreement sought Milliman's expertise for indexing Texas workers' compensation system inpatient and outpatient facility reimbursement to Medicare facility reimbursement. Milliman has extensive experience in designing and pricing insurance products; helping HMOs, preferred provider organizations (PPOs), and insurance carriers set up managed care networks; researching and analyzing health care systems' claims data and reimbursement analysis and rate setting; developing fee guidelines/schedules; and working with governmental and regulatory entities and projecting financial results for clients.

The Division provided Milliman with the 837 data set for CY 2005, which included information on approximately 12,000 inpatient billing lines and 166,000 hospital outpatient billing lines.

Based on the analysis of the Division's 837 data, Milliman estimated that Texas workers' compensation reimbursement for CY 2005 inpatient hospital stays represented approximately 115 percent of 2007 Medicare allowable levels. This percentage varies significantly by type of service, case, payor, and provider. Most notable is the difference in the percentage between hospital stays with low and high billed charge amounts. For hospital stays with less than \$40,000 in billed charges, the Texas workers compensation payments represented 66 percent of Medicare allowable amounts. For hospital stays with \$40,000 or more

in billed charges, the Texas workers' compensation payments represented 160 percent of Medicare allowable amounts.

Milliman's report included information on surgically implanted devices as a percentage of inpatient reimbursement for all cases and as a percentage of reimbursement for cases with surgically implanted devices. For all cases, surgically implanted devices represented 25 percent of the total reimbursement. For cases with surgically implanted devices, the reimbursement for those devices was 36.5 percent of total reimbursement for inpatient admissions with charges for implants.

Milliman's analysis of CY 2005 outpatient hospital data included 54 percent of the Texas workers' compensation payments for hospital outpatient services. These payments, however, totaled over \$60 million. Based on those claims with sufficient data to be analyzed and re-priced using CMS' methodology, Milliman estimated that CY 2005 Texas workers' compensation outpatient facility reimbursement represented approximately 186 percent of Medicare allowable levels for outpatient services. As noted in the inpatient results, this percentage varies significantly by type of service, case, payor, and provider.

Milliman's report included information on surgically implanted devices as a percentage of outpatient reimbursement for all cases and as a percentage of reimbursement for surgical cases. For all cases, surgically implanted devices represented 8.6 percent of the total reimbursement.

MARKET REIMBURSEMENT

Texas Hospital Association (THA) Survey

The Division requested the assistance of the THA in coordinating the collection of billing and reimbursement information for services currently provided by Texas hospitals in the Texas workers' compensation system. THA's survey results are available from the Division upon request, at a cost for reproduction.

The Division provided THA with a list of Medicare DRGs most frequently billed in the Texas workers' compensation system. The DRG list was based upon THCIC's public data file. The Division asked THA to survey its members to provide detailed aggregate charges and reimbursements for these DRGs by payor type in order to have a better understanding of the general reimbursement relationships between Medicare, HMOs, PPOs, commercial indemnity, and Texas workers' compensation plans.

Below are some of THA's inpatient survey results represented in percentages of payments to charges for CYs 2005 and 2006 by payor type:

* CY 2006: Inpatient HMOs and PPOs combined reflected a ratio of 42 percent of payments to charges, Medicare a ratio of 25.4 percent, and workers' compensation a ratio of 35.3 percent. The ratio of payments to charges for all implants and carve-outs reflected for HMOs and PPOs combined was 28.9 percent, for Medicare a ratio of 21.4 percent, and for workers' compensation a ratio of 38 percent.

* CY 2005: Inpatient HMOs and PPOs combined reflected a ratio of 39 percent of payments to charges, Medicare a ratio of 26.1 percent, and workers' compensation a ratio of 35.9 percent. The ratio of payments to charges for all implants and carve-outs reflected for HMOs and PPOs combined was 27.4 percent, for Medicare a ratio of 20.8 percent, and for workers' compensation a ratio of 35.4 percent.

The same type of outpatient survey results are as follows:

* CY 2006: Outpatient HMOs and PPOs combined reflected a ratio of 39 percent of payments to charges, Medicare a ratio of 16.4 percent, and workers' compensation a ratio of 46.3 percent. The ratio of payments to charges for all implants and carve-outs reflected for HMOs and PPOs combined was 8.7 percent, for Medicare a ratio of 13.3 percent, and for workers' compensation a ratio of 10.3 percent.

* CY 2005: Outpatient HMOs and PPOs combined reflected a ratio of 41.4 percent of payments to charges, Medicare a ratio of 17.0 percent, and workers' compensation a ratio of 49.2 percent. The ratio of payments to charges for all implants and carve-outs reflected for HMOs and PPOs combined was 8.7 percent, for Medicare a ratio of 12.6 percent, and for workers' compensation a ratio of 9.8 percent.

Ingenix, Inc.

The previous Texas Workers' Compensation Commission (Commission) entered into a professional services agreement with Ingenix in June 2001, and again in the summer of 2005, to benchmark workers' compensation payments to current health care market reimbursement rates. Ingenix is a professional firm specializing in actuarial and health care information services, and assisted the Commission in developing §134.402, which addresses facility fees for health care services provided in an ambulatory surgery center facility.

When conducting its research, Ingenix analyzed hospital inpatient and outpatient services and ASC services separately. In defining the market, Ingenix utilized commercial payor information that is reflective of the current reimbursement for the various payor types such as HMOs, PPOs, point of service (POS) plans, and traditional fee for service health plans (indemnity plans). Commercial reimbursement reflects, for the most part, negotiated rates based on both carriers' and providers' business plans. The combined Medicare market data and commercial market data reflected the actual reimbursement for services provided in the health care market.

Historical Commission medical claims data provided a Texas workers' compensation mix of services for use in the analysis. This utilization pattern was applied to the commercial market (HMO, PPO, POS, and indemnity plans) and Medicare reimbursement levels, establishing an estimated reimbursement for a workers' compensation case mix.

In a report dated August 29, 2005, Ingenix provided actuarial data regarding the mix of insured people by coverage type (Medicare, HMO, POS, PPO, and indemnity plans); the relative utilization factors for each payor group; and the relative reimbursement for each payor type as a percent of Medicare reimbursement. The combination of covered population and utilization rates yields a market share for each type. When this market share information is combined with relative reimbursement rates, a weighted average for the market is calculated. Depending on the definition of the market, i.e., either including or excluding specific payor types, a range of reimbursement for the market may be developed. Additional analysis provided the ratio to Medicare of each coverage type's payment levels for each year from 2003 through 2008. Based on the information included in the Ingenix reports, the Division estimated the inpatient market between 112 percent and 147 percent of Ingenix projected 2008 Medicare rates. Additionally, the Division estimated the outpatient market between 163 percent and 217 percent of Ingenix projected 2008 Medicare rates.

The Division has not included the payment adjustment factors recommended in the Ingenix original 2002 report due to the age of the recommendations and because the recommendations were specific to the draft proposal inpatient and outpatient guidelines being developed in 2002. However, in preparing the currently adopted rules the Division has considered the

applicable market information and projections through 2008 contained in the August 2005 Ingenix update report.

ECONOMIC INDICATORS

Medicare Payment Advisory Commission (MedPAC)

MedPAC is an independent federal body established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program such as access to care, quality of care, and other issues affecting Medicare. MedPAC meets publicly to discuss policy issues and formulate its recommendations to the Congress.

Two reports, issued in March and June each year, are the primary outlet for MedPAC recommendations. In its March 2007 Medicare Payment Policy report to the Congress, MedPAC included a section in Chapter 2 on hospital inpatient and outpatient services which pointed out trends in Medicare margins and data analysis showing that costs have risen faster than the market basket (a group of products or services used specifically to track the progress of inflation in a specific market) in recent years. According to MedPAC, the overall Medicare margin (calculated as payments minus costs, divided by payments) has trended downward since 1997 falling to -3.3 in 2005. However, the 0.2 percentage point decline from 2004 to 2005 was the smallest in the last five years. The Medicare inpatient margin decreased by 0.4 percentage point in 2005 to -0.9 percent while the outpatient margin improved for the second year in a row, though it is still

lower than the inpatient margin. MedPAC estimates that the Medicare margin in 2007, reflecting 2008 payment policies other than updates will be -5.4 percent. According to MedPAC, the key factor explaining the forecasted decline in margin for 2007, in addition to policy changes, is preliminary evidence that the rate of growth in hospitals' unit costs will exceed the forecasted growth in the hospital market basket index (inflationary measure of the costs and goods of services purchased by hospitals).

MedPAC states that the weighted average of Medicare inpatient and outpatient costs, unadjusted for changes in case mix, increased by 5.3 percent in 2004 and by 5 percent in 2005. Lowering the number to take reported case-mix increases into account, the weighted average cost increase was 4.6 percent in 2004 and 3.7 percent in 2005. The 3.7 percent rate of cost growth in 2005 was slightly more than the 3.3 percent operating update hospitals received from Medicare in 2005. Looking at inpatient costs separately, MedPAC reports that unadjusted inpatient costs per discharge increased by 5.6 percent in 2004 and 5.1 percent in 2005. Case-mix-adjusted inpatient costs rose 5.4 percent in 2004 and 4.0 percent in 2005. Medicare outpatient cost per unit of service (adjusted for case-mix change) has been relatively low, increasing by only 1.2 percent in 2004 and 2.4 percent in 2005. Data are available on case-mix-adjusted Medicare costs through 2005 but are not yet available for 2006. However, MedPAC reports that a survey sponsored by CMS and MedPAC of about 600

hospitals indicates that unadjusted costs per unit of service grew by approximately 5.2 percent in the fiscal year ending June 2006, slightly higher than the rate of 4.8 percent in the prior year. MedPAC also reviewed financial reports from six large publicly traded hospitals that show that their unadjusted growth in cost averaged 6.4 percent per year in the nine months ending September 2006, relative to 4.8 percent in 2005. MedPAC projected that if one averages data from these two samples, costs per discharge appear on pace to grow roughly 1 percent faster in 2006 than in 2005.

MedPAC explains that one reason 2006 differs from 2005 is that capital costs are increasing more rapidly. According to MedPAC, a second reason is that patient volume grew more slowly than hospital employment in the first half of the year; in contrast to 2005. Additionally, MedPAC provides extensive justification for these two reasons.

In its analysis of Medicare cost report data from CMS and CMS's rules for the acute IPPS, MedPAC reports that costs have risen faster than the market basket in recent years. MedPAC examined cost growth during three periods 1986-1992, 1993-1999, and 2000-2004 and concluded that the rate of increase tended to follow trends in private payor profitability in the same three periods. MedPAC reports that during the first cycle (1986 through 1992) most insurers still paid hospitals on the basis of their charges, with little price negotiation or selective contracting and hospital margins on private payor business increased

rapidly. MedPAC further states that in the mid-1990's, HMOs and other private insurers negotiated better and most insurers switched to paying for inpatient services on the basis of DRGs or flat per diem amounts for broad types of services. MedPAC then explains that the payment, cost-to-cost ratio for private payors, declined by 17 percentage points from 1993 through 1999. MedPAC reports that by 2000, hospitals had regained the upper hand in price negotiation due to consolidations and consumer backlash against managed care. Rates for private payors rose rapidly and their payment-to-cost ratio rose by 11 percentage points from 2000-2004 and from 2001-2004, increases in private payor profitability were accompanied by hospital costs rising at a rate faster than the market basket. MedPAC saw the trend in private payor profit margins leveling off in 2005 and cost growth returning to a level close to the market basket increase.

According to MedPAC, the private sector is not the only potential source of financial pressure on hospitals; Medicare payment rates can also influence cost growth. The report further states that in recent years, Medicare inpatient payments have increased at a rate higher than the hospital market basket (reflecting updates equal to the market basket plus a small additional increase due to case-mix change), but payments have not risen fast enough to accommodate the rapid increase in hospital costs. MedPAC reports that by not fully accommodating growth in hospital costs, Medicare can put some pressure on hospitals to constrain costs.

MedPAC concludes in its report that most of its indicators of payment adequacy for hospital services are positive, although Medicare margins are low and recent cost trends suggest they will fall in 2007. At the same time, MedPAC suggests that hospitals with consistently high costs and low margins that have contributed to the industry-wide Medicare margin falling below zero are a fairly small percentage, fewer than a fifth, and opines that Medicare should put pressure on hospitals to control their costs rather than accommodate the current rate of costs growth. Balancing those considerations, MedPAC recommends that Congress should increase payment rates for the acute inpatient and outpatient PPS in 2008 by the projected rate of increase in the market basket index, concurrent with implementation of a quality incentive program. The inpatient update would apply to fiscal year 2008 and the outpatient update would apply to CY 2008. As of MedPAC's March 2007 Report, CMS' latest forecast of the hospital operating market basket index for fiscal year 2008 is 3.1 percent; it will update the forecast twice before using it to update payments in 2008.

SYSTEM PARTICIPANT INPUT AND RECOMMENDATIONS

Data Methodology Committee

In March 2007 a Data Methodology Committee was established and comprised of members recommended by the hospital and insurance industries to assist the Division with technical aspects of development of the hospital fee guidelines. The committee's focus was on data analysis and modeling as it

impacts or explains the use of Medicare methodologies in the Texas workers' compensation system.

The Data Methodology Committee met over the course of five months (March – July) and reviewed and discussed numerous issues, including:

- * the research of other states' (California, Colorado, New York, Nebraska, and South Carolina) hospital reimbursement systems, including any noted provisions for surgical implants, or implantables;
- * spreadsheets developed by THA that included adjusted base calculations and the range of the adjusted base calculations for Texas hospitals;
- * Medicare's outpatient pass-through concept for collecting data to set APCs similar to DRGs used for inpatients, as well as hospitals' cost-to-charge ratios; and
- * complexities of implantable devices and the difficulties surrounding hospitals' charge compressions.

The committee also met to hear a presentation by Access MediQuip, L.L.C., a national provider of implantable and specialty surgical devices, who described its working relationship as the go-between for certain carriers, hospital systems, and other states in facilitating the procurement of implantable devices and managing the preauthorization and billing processes.

The Division, as recommended by the committee, conducted research of other states' fee schedules, as well as those states' separate reimbursement

methodologies for implantables, and used concepts from that research in the development of the proposed rules. Additionally, the Division invited members from Access MediQuip to meet with the committee members for further rule development concepts.

"Recommendations for a Texas Inpatient Hospital Fee Guideline" Report

Texas Mutual Insurance Company and several other workers' compensation insurance carriers commissioned Research & Planning Consultants, LP (RPC) for the purpose of developing a report that provided information, analysis, and recommendations for use in the rulemaking process. RPC's report, at the cost for copying, is available at the Division upon request. As described in the report's section entitled, "Organization of the Report," the study includes a detailed description of the Medicare IPPS and discusses the methodology used by Medicare to calculate payment rates with all adjustments to the basic payment rates and any applicable add-on payments included. The report additionally covers:

- * types of facilities and services that are subject to special payments or excluded;
- * an examination and comparison of payment adjustment factors in four states (California, North Dakota, Ohio, and South Carolina) who have preceded Texas in implementing a Medicare-based inpatient hospital fee guideline;

* description of data sets used to formulate recommendations contained in the report;

* analysis of DRG weights and other considerations, and differences in relative costs by DRGs between workers' compensation and Medicare patients; and

* a series of recommendations, which includes (1) adoption of Medicare's transfer payment policy and the three-policy-based adjustments; (2) a single payment adjustment factor of 105.9 percent applied to Medicare that simply adjusts for the difference between the Medicare payment rates and the costs incurred by hospitals treating workers' compensation patients; and (3) an alternate set of payment adjustment factors that allows for a carve-out for high implant charge DRGs (114.9 percent), and a re-distributed payment adjustment factor of 100.8 percent for all other DRGs.

The RPC Report, including the overview of Medicare's IPPS and data analysis, were utilized for comparative purposes in the development of the adopted rules. Much of the Division's analysis and the adopted payment adjustment factors for §134.404 showed similarities with comparable RPC analysis and recommendations.

Hospital Fee Schedule Proposal by Renaissance Healthcare Systems, Inc.
(Renaissance)

Renaissance, a network of community health systems, provided the Division with a "Hospital Fee Schedule Rules Proposal" that described its research of other states' hospital fee guidelines, with a focus on Tennessee, Florida, and California. Renaissance gathered information and determined the percentage of Medicare reimbursement by analyzing the operating room and administrative costs to Renaissance for outpatient services. Additionally, Renaissance added patient day costs for the inpatient calculations. With this determination, Renaissance compared the information to Renaissance actual Medicare reimbursements for each of those services and arrived at the percentage of Medicare that Renaissance determined would provide a 15 percent net profit margin in order to serve health care to the community. Consequently, for inpatient hospital fee reimbursements, Renaissance recommended a range of 155-170 percent of Medicare, and for outpatient hospital fee reimbursements, a range of 225-255 percent of Medicare. Additionally, for inpatient services, Renaissance recommended the adoption of stop-loss provisions to be paid at 75 percent of billed charges, less the charges for implantables, when total billed charges exceed \$50,000, after the removal of the charges for implantables.

Other States Research

In preparing for the revision and development of the facility fee guidelines, the Division researched the payment methodologies and reimbursement rates of

other states workers' compensation programs. Of primary interest was the general topic of other states' use of the Medicare system as a basis for reimbursement. Although many states refer to the Medicare program, each state's unique legislative requirements result in a diverse set of rules and procedures. Per diem reimbursement, cost-to-charge ratios, discounts from billed charges, and DRG based reimbursements are being used. Some states invoke Medicare and quickly diverge from the Medicare model. Consequently, direct comparisons of the various states to Texas are difficult and may lead to erroneous conclusions. The states that seem to have significantly embraced a Medicare based system are California, South Carolina, North Dakota, and Ohio. The inpatient allowable for these states ranges from 115 percent to 140 percent of Medicare reimbursement. Still each of these states has unique variations that ultimately modify the specific reimbursement for each admission.

Payment for outpatient services reflects the same diversity. Discounts from billed charges and cost-to-charge ratios reimbursement are common. Payment based on Medicare's OPSS is used in California, North Dakota, South Carolina, Tennessee, and Washington. Reimbursement rates vary among these five states. Tennessee is at the upper end of the range with a fee schedule set at 150 percent of Medicare.

For both the inpatient and outpatient settings, states have a wide variety of rules that modify their general payment approach. These include carve-outs for

specific items, stop-loss reimbursement, and various other payment exclusions or restrictions.

HOSPITAL FEE GUIDELINES RESULTS/CONCLUSIONS AND EXPLANATIONS

In developing the adopted hospital fee guidelines, the Division has carefully and fully analyzed all of the statutory and policy mandates and objectives and all the facts and evidence gathered and submitted, as well as all informal system participants' input and comments received throughout the development process, including written comments to the proposed inpatient and outpatient guidelines and public hearing testimony on the proposed rules. The Division has utilized the information gathered and submitted, along with its expertise and experience, to develop these hospital fee guidelines in a way that best balances the statutory mandates, including the mandate to ensure that injured employees receive the quality health care reasonably required by the nature of their injury, the mandate to ensure that fee guidelines are fair and reasonable, and the mandate to achieve effective medical cost control.

Setting Payment Adjustment Factors (PAFs)

In adopting PAFs for use in §134.403 and §134.404, the Division has conducted extensive research to understand hospital reimbursement in the current Texas workers' compensation system, including: reimbursement rates, the reimbursement rates as compared to Medicare reimbursement, and the

reimbursement rates as compared to non-workers' compensation reimbursement for hospital services.

The Division has also considered economic indicators for hospitals that are particularly relevant to the analysis process. Hospital Medicare margins and hospital market basket information reflect the general increasing costs of hospital care over time.

Overall, CY 2005 Texas workers' compensation reimbursement rates for inpatient and outpatient services as a percentage of billed charges are 33 percent and 37 percent respectively. Additionally, Milliman has reviewed Texas workers' compensation facility utilization and reimbursement. The report prepared by Milliman did not recommend a PAF, however, it did estimate that for CY 2005 services facilities were paid on average 115 percent of Medicare for inpatient services and on average 186 percent of Medicare for outpatient services. Reimbursement rates at these levels would generally maintain overall system costs at CY 2005 levels.

The Division, however, must consider additional factors in setting the PAFs. The ratio of Medicare reimbursement to reimbursement made by other payors is an important comparison. In adopting a PAF, the Division has noted and considered the recommendations made by system stakeholders. Those recommendations range from 100 percent to 170 percent of Medicare for inpatient services, and 100 percent to 266 percent of Medicare for outpatient

TITLE 28. INSURANCE

Part 2. Texas Department of Insurance,

Division of Workers' Compensation

Chapter 134. Benefits-Guidelines for Medical Services, Charges, and Payments

Adopted Sections

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services. These rates were paired with various adjustments to the overall Medicare reimbursement methodology. Additionally, the Division has considered information provided by Ingenix relating to the market share of inpatient and outpatient services for Medicare, HMO, PPO, POS, and commercial indemnity payor groups and the reimbursement rates of those payors when indexed to Medicare payments. This set of reimbursement rate recommendations and observations provides a general range of rates that is reflective of the current hospital market to consider in adopting a PAF.

The Division must consider the issues of medical cost containment as prescribed by Labor Code §413.011. The Texas workers' compensation system has been noted as a state with high medical costs per claim. Cognizant of this distinction, the Division must balance any change in the reimbursement rate with the facts of Texas high medical costs per claim and access to care. Research conducted by the Workers' Compensation Research Institute concludes that hospital inpatient payments per episode and hospital outpatient payments per claim in Texas were lower than the 13-state median studied. (Workers' Compensation Research Institute, *Baselines for Evaluating the Impact of the 2005 Reforms in Texas and an Early Look at the Impact of the 2003 Fee Schedule Changes: The Anatomy of Worker's Compensation Medical Costs and Utilization*, (Summary of Major Findings for Texas) 6th Edition, xiii, February 2007))

Medicare's methodology does not include a separate reimbursement for surgically implanted devices, with the exception of new technology; however, separate reimbursement for surgically implanted devices is used in some instances in the commercial market. This fee guideline is developed to both use the most current methodologies, models, values, or weights used by the CMS and reflect the commercial market's use of separate reimbursement for surgically implanted devices. The Division is adopting a minimal modification to Medicare's reimbursement methodology to reflect use of separate reimbursement for surgically implanted devices in order to ensure injured employees have access to care, including surgery where surgically implanted devices are medically necessary. The modification establishes two PAFs in each adopted section. For the Inpatient Hospital Fee Guideline, the adopted PAFs are 143 percent and 108 percent of Medicare. The adopted PAFs for the Outpatient Hospital Fee Guideline are 200 percent and 130 percent of Medicare.

Hospitals will have the option to choose the higher or lower PAF for each guideline. The higher PAF contemplates the inclusion of reimbursement for surgically implanted devices as a part of the DRG. If the hospital chooses the lower PAF, the surgically implanted device(s) will be reimbursed separately at cost plus an administrative expense fee. The administrative expense fee is set at 10 percent or \$1,000 per item add-on, whichever is less, but will not exceed \$2000 in add-on's per admission. If the hospital is reimbursed the lower PAF,

the cost of the surgically implanted device(s), including the administrative expense fee, will not be considered in determining eligibility for outlier payments.

The Division's adopted PAFs take into consideration Milliman's estimate that Texas workers' compensation reimbursement for CY 2005 inpatient hospital stays represented approximately 115 percent of 2007 Medicare allowable levels and the difference in the percentage between hospital stays with low- and high-billed charge amounts.

For inpatient hospital stays with less than \$40,000 in billed charges, Milliman estimated Texas workers' compensation payments represented 66 percent of Medicare allowable amounts. For inpatient hospital stays with \$40,000 or more in billed charges, Milliman estimated Texas workers' compensation payments represented 160 percent of Medicare allowable amounts.

In determining the adopted PAFs for inpatient hospital stays, the Division adjusted the reimbursement for hospital stays with less than \$40,000 to reflect reimbursement at 100 percent of Medicare. This adjustment changes Milliman's estimated Texas workers' compensation reimbursement for CY 2005 inpatient hospital stays reimbursed less than \$40,000 from 115 percent to 131 percent of Medicare's allowable reimbursement.

Similarly, reimbursement for inpatient hospital stays with billed charges greater than \$40,000 was reviewed. Reimbursement at 160 percent of Medicare

allowable reimbursement approximated 35 percent of billed charges. If the commercial standard of approximately 40 percent of billed charges is met for these inpatient hospital stays, overall reimbursement increases to 143 percent of Medicare allowable reimbursement. The Division used this standard as the benchmark for reimbursement.

The estimated reimbursement for all inpatient hospital stays, those with reimbursement less than \$40,000, and reimbursement greater than \$40,000, changes from 115 percent to 143 percent of Medicare's allowable reimbursement.

In setting a PAF for inpatient hospital stays with a separate reimbursement for surgically implanted devices, the surgically implanted device costs are removed from the higher proposed PAF, 143 percent. To determine the amount of reimbursement to be removed from this PAF, the Division analyzed reimbursements for surgically implanted devices as a percentage of total reimbursement.

Milliman's report included information on surgically implanted devices as a percentage of inpatient reimbursement for all inpatient hospital stays and as a percentage of reimbursement for inpatient hospital stay with surgically implanted devices. For all cases, surgically implanted devices represented 25 percent of the total reimbursement. For cases with surgically implanted devices, the total

implantable reimbursement for those devices was estimated to be 28.7 percent of total estimated Medicare inpatient reimbursement.

The Division considered actual implantable reimbursement in determining the offset. Actual reimbursement for inpatient hospital stays with implantables was 35 percent of Medicare's allowable reimbursement. This dollar amount represents reimbursement on a cost-plus basis and the same methodology is carried over the reimbursement methodology. Therefore, the Division's adopted PAF for inpatient stays with separate reimbursement for surgically implanted devices is 35 percentage points less than the higher PAF. This adjustment should insulate hospitals for potential losses as a result of high cost implants by assuring that if costs for an implant exceed 35 percent of the DRG, the hospital has the option of recovering the total cost of the implant.

Milliman's report on outpatient reimbursement indicated CY 2005 Texas workers' compensation reimbursement is approximately 186 percent of Medicare allowable reimbursement. Milliman's report also noted that one workers' compensation payor reimbursed at a significantly lower rate than the average payor. Adjusting for this anomaly, reimbursement moves to approximately 211 percent of Medicare allowable reimbursement. The Division also compared the general benchmark of 40 percent of billed charges which was equal to approximately 200 percent of the Medicare allowable reimbursement. This benchmark is based upon THA survey data.

In determining the PAFs for outpatient hospital stays, the Division considered Medicare's methodology for reimbursing device-dependent services. Medicare establishes a device offset to recognize the average implantable cost as it relates to reimbursement for a specific APC. Milliman's report indicated five APCs with an average implantable devices offset of 70 percent. The entire list of APCs identified as device-dependent by Medicare indicates an average implantable device offset of 75 percent. Since CMS identified the relative reimbursement for these devices, the Division was able to directly remove the 70 percent offset from the overall outpatient reimbursement PAF of 200 percent, resulting in a second PAF of 130 percent for use when billing implantables separately.

Based on all of these factors, the Division adopts PAFs of 143 percent and 108 percent of Medicare reimbursement for use in determining Texas workers' compensation inpatient facility service reimbursement. The Division adopts PAFs of 200 percent and 130 percent of Medicare reimbursement for use in determining Texas workers' compensation outpatient facility service reimbursement.

In response to comments from interested parties, the Commissioner has adopted these sections with some changes to the proposal as published.

§134.403. In subsection (b)(2)(D) and (E), respectively, additional language, “and” as well as “related equipment necessary to operate, program, and recharge the implantable” are changes from proposal as a result of public comments to clarify that implant-related equipment necessary to operate, program, and recharge the actual implantable device should be billable and reimbursable along with the actual implant devices. In subsection (g), additional language, “per billed item, add-on” is a change from proposal as a result of public comment to clarify that the \$1,000 limit can potentially extend to multiple implantable items. This limit allows for the recognition of the administrative cost but discourages the unbundling of implantables associated with expensive items. Further, additional language in subsection (g) “but not to exceed \$2,000 in add-on’s per admission” is also a change from proposal. The limit of per admission should cover the administrative charges in most cases, and prevent an excessive administrative add-on for any individual item. Consequently, in the interests of effective medical cost control, the limit of \$2,000 per admission is included in the adopted rules. As proposed, subsection (g) included (g)(4), however, as adopted, the Division changes (g)(4) to new subsection (h) as applicable to the entire section and not just the subsection and re-numbers the subsequent subsections accordingly.

§134.404. In subsection (b)(2) (D) and (E) respectively, additional language, “and” as well as “related equipment necessary to operate, program, and recharge the implantable” are changes from proposal as a result of public comments to

clarify that implant-related equipment necessary to operate, program, and re-charge the actual implantable device should be billable and reimbursable along with the actual implant devices. In subsection (g), additional language, "per billed item, add-on" is a change from proposal as a result of public comment to clarify that the \$1,000 limit can potentially extend to multiple implantable items. This limit allows for the recognition of the administrative cost but discourages the unbundling of implantables associated with expensive items. Further additional language in subsection (g) "but not to exceed \$2,000 in add-on's per admission" is also a change from proposal. The limit of per admission should cover the administrative charges in most cases, and prevent an excessive administrative add-on for any individual item. Consequently, in the interests of effective medical cost control, the limit of \$2,000 per admission is included in the adopted rules.

3. HOW THE SECTIONS WILL FUNCTION.

Adopted new §134.403(a) describes the applicability of the section. Adopted new §134.403(a)(1) states that the section applies to medical services provided in an outpatient acute care hospital on or after March 1, 2008. Adopted new §134.403(a)(2) notes that the section does not apply to professional medical services billed by a provider not employed by the hospital, except for a surgical implant provider as described in the section; and, that it is not applicable to services provided through a workers' compensation health care network certified

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pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

Adopted new §134.403(b) provides definitions for words and terms that are used in the section. Adopted new §134.403(b)(1) defines the term “acute care hospital” to mean a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma. Adopted new §134.403(b)(2) defines the term “implantable” to mean an object or device that is surgically implanted, embedded, inserted, or otherwise applied, and, includes related equipment necessary to operate, program and recharge the implantable. Adopted new §134.403(b)(3) defines “Medicare payment policy” to mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the CMS payment policies specific to Medicare. Adopted new §134.403(b)(4) defines the term “outpatient” to mean the patient is not admitted for inpatient or residential care, and includes observation in an outpatient status provided the observation period complies with Medicare policies. Adopted new §134.403(b)(5) defines the term “surgical implant provider” to mean a person that arranges for the provision of implantable devices to a health care facility and that then seeks reimbursement for the implantable devices provided directly from an insurance carrier.

Adopted new §134.403(c) clarifies that a surgical implant provider is subject to Chapter 133 of this title and is considered a health care provider for purposes of the section and the sections in Chapter 133 of this title (relating to Benefits – Medical Benefits).

Adopted new §134.403(d) requires that for coding, billing, reporting, and reimbursement of health care covered in the section, Texas workers' compensation system participants shall apply Medicare payment policies in effect of the date a services is provided with any additions or exceptions specified in the section. Adopted new §134.403(d)(1) provides that specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, as taking precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program. Adopted new §134.403(d)(2) provides that Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, as taking precedence in that case only, over any Division rules and Medicare payment policies. Adopted new §134.403(d)(3) provides for the stated inclusion that whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on

and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later.

Adopted new §134.403(e) establishes that regardless of billed amount, reimbursement shall be determined in the following order. The first method is in §134.403(e)(1) and indicates the amount for the service is the amount included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011. The second method is in §134.403(e)(2) and states that if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount is as described under subsection (f) of the section, including any applicable outlier payment amounts and reimbursement for implantables. The last method is in §134.403(e)(3) and states that if no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of the section, then reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

Adopted new §134.403(f) requires that the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare OPPS reimbursement formula and factors as published annually in the *Federal Register*, with the minimal modifications noted

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in the following paragraphs. Adopted new §134.403(f)(1) indicates that the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent. Adopted new §134.403(f)(2) establishes that when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

Adopted new §134.403(g) addresses the use of implantables, and states, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of the section, implantables shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000, per billed item add-on, whichever is less, but not to exceed \$2,000 in add-ons per admission. Adopted new §134.403(g)(1) establishes that a facility or surgical implant provider billing separately for an implantable, shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge." Adopted new §134.403(g)(2)

states that a carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) properly reflects the requirement of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding §133.307(d)(2)(B). Adopted new §134.403(g)(3) provides that nothing in the rule precludes a health care facility or insurance carrier from utilizing a surgical implant provider to arrange for the provision of implantable devices, and that implantables provided by a surgical implant provider shall be reimbursed according to the subsection.

Adopted new §134.403(h) establishes that for medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

Adopted new §134.403(i) clarifies that, notwithstanding Medicare payment policies, whenever Medicare requires a specific setting for a service, that restriction shall apply, unless an alternative setting and payment has been approved through the Division's preauthorization, concurrent review, or voluntary certification of health care process.

Adopted new §134.403(j) provides that a preauthorization request may be submitted for an alternative facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request. Copies of the agreement are to be kept by both parties; and, the agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1). Adopted new §134.403(j)(1) establishes that the agreement between the insurance carrier and the party that requested the alternative facility setting must be in writing, in clearly stated terms, and must include the reimbursement amount; a description of the services to be performed under the agreement; any other provisions of the agreement; and the names of the entities, titles, and signatures of both parties, and names, titles, signatures with dates of the persons signing the agreement. Adopted new §134.403(j)(2) states that an agreement for an alternative facility setting may be revised during or after preauthorization by written agreement of the insurance carrier and the party that requested the alternative facility setting. Adopted new §134.403(j)(3) requires that upon request of the Division, all agreement information shall be submitted in the form and manner prescribed by the Division.

Adopted new §134.403(k) establishes the severability of this section and states that if a court of competent jurisdiction holds that any provision of the section is inconsistent with any statutes of this state, are unconstitutional, or are

invalid for any reason, the remaining provisions of this section shall remain in full effect.

Adopted new §134.404(a) describes the applicability of the section. Adopted new §134.404(a)(1) states that the section applies to medical services provided in an inpatient acute care hospital with an admission date on or after March 1, 2008. Adopted new §134.404(a)(2) describes that for admission dates prior to March 1, 2008, the law and the Texas Department of Insurance, Division of Workers' Compensation (Division) rules in effect for those dates of services shall apply. Adopted new §134.404(a)(3) notes the section does not apply to professional medical services billed by a provider not employed by the hospital, except for a surgical implant provider as described in this section; and, it is not applicable to services provided through a workers compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

Adopted new §134.404(b) provides definitions for word and terms that are used in the section. Adopted new §134.404(b)(1) defines the term "acute care hospital" to mean a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma. Adopted new §134.404(b)(2) defines the term "implantable" to mean an object or device that is surgically implanted, embedded, inserted, or otherwise applied, and includes

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related equipment necessary to operate, program, and recharge the implantable.

Adopted new §134.404(b)(3) defines "Medicare payment policy" to mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the CMS payment policies specific to Medicare. Adopted new §134.404(b)(4) defines the term "outlier payment amount" to mean the amount determined by Medicare's IPPS calculations for unusually costly services. Adopted new §134.404(b)(5) defines the term "surgical implant provider" to mean a person that arranges for the provision of implantable devices to a health care facility and that then seeks reimbursement for the implantable devices provided directly from an insurance carrier.

Adopted new §134.404(c) clarifies that a surgical implant provider is subject to Chapter 133 of this title and is considered a health care provider for purposes of this section and the sections in Chapter 133 of this title (relating to Benefits – Medical Benefits).

Adopted new §134.404(d) requires that for coding, billing, reporting, and reimbursement of health care covered in the section, Texas workers' compensation system participants shall apply Medicare payment policies in effect of the date a services is provided with any additions or exceptions specified in the section. Adopted new §134.404(d)(1) provides that specific provisions contained in the Texas Labor Code or the Division rules take precedence over

any conflicting provision adopted or utilized by the CMS in administering the Medicare program. Adopted new §134.404(d)(2) provides for the inclusion of IRO decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title, which are made on a case-by-case basis, as taking precedence in that case only, over any Division rules and Medicare payment policies. Adopted new §134.404(d)(3) provides that whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later.

Adopted new §134.404(e) establishes that except as provided in subsection (h) of the section, regardless of billed amount, reimbursement shall be determined in the following order. The first method is in §134.404(e)(1) and indicates the amount for the service is the amount included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011. The second method is in §134.404(e)(2) and states that if no contracted fee schedule exists that complies with Labor Code §413.011, the MAR amount is as described under subsection (f) of the section, including all applicable outlier payment amounts and reimbursement for implantables. The last method is in §134.404(e)(3) and states that if no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be

determined by application of the formula to calculate the MAR as outlined in subsection (f) of the section, then reimbursement shall be determined in accordance with §134.1 of this title.

Adopted new §134.404(f) requires that the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare IPPS reimbursement formula and factors as published annually in the *Federal Register*, with the following minimal modifications applied to it. Adopted new §134.404(f)(1) indicates that the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent, unless a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of the section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent. Adopted new §134.404(f)(2) establishes that when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of the section.

Adopted new §134.404(g) addresses the use of implantables, and states, that when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of the section, implantables shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount

(exclusive of rebates and discounts), plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission.

Adopted new §134.404(g)(1) establishes that a facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

Adopted new §134.404(g)(2) states that a carrier may use the audit process under §133.230 of this title to seek verification that the amount certified under paragraph (1) properly reflects the requirement of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title, if that process is properly requested, notwithstanding §133.307(d)(2)(B). Adopted new §134.404(g)(3) provides that nothing in the rule precludes a health care facility or insurance carrier from utilizing a surgical implant provider to arrange for the provision of implantable devices, and that implantables provided by a surgical implant provider shall be reimbursed according to subsection (g).

Adopted new §134.404(h) establishes that a hospital that is classified by Medicare as a Sole Community Hospital, a Medicare Dependent Hospital, or a Rural Referral Center Hospital, shall initially be paid the amount calculated for

such a hospital in accordance with to subsections (e) through (g) of the section, that if the initial payment is less than the cost of the services in question, the hospital may request reconsideration in accordance with §133.250 of this title and present documentation of any amount it would have been paid under the Medicare regulations in effect when the services were performed. If such a showing is made, the hospital shall be paid the difference between the amount initially paid and the amount Medicare would have paid for the services as adjusted by the appropriate multiplier.

Adopted new §134.404(i) clarifies that, notwithstanding Medicare payment policies, whenever Medicare requires a specific setting for a service, that restriction shall apply, unless an alternative setting and payment has been approved through the Division's preauthorization, concurrent review, or voluntary certification of health care process.

Adopted new §134.404(j) provides that a preauthorization request may be submitted for an alternative facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request and that copies of the agreement are to be kept by both parties; and, the agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1). Adopted new §134.404(j)(1) establishes that the agreement between the insurance carrier and the party that requested the alternative facility setting must be in writing, in clearly stated terms,

and must include the reimbursement amount; a description of the services to be performed under the agreement; any other provisions of the agreement; and the names of the entities, titles, and signatures of both parties, and names, titles, signatures with dates of the persons signing the agreement. Adopted new §134.404(j)(2) states that an agreement for an alternative facility setting may be revised during or after preauthorization by written agreement of the insurance carrier and the party that requested the alternative facility setting. Adopted new §134.404(j)(3) requires that upon request of the Division, all agreement information shall be submitted in the form and manner prescribed by the Division.

Adopted new §134.404(k) establishes the severability of the section and states, if a court of competent jurisdiction holds that any provision of the section is inconsistent with any statutes of this state, are unconstitutional, or are invalid for any reason, the remaining provisions of the section shall remain in full effect.

4. SUMMARY OF COMMENTS AND AGENCY'S RESPONSE TO COMMENTS.

§134.403: Some commenters appreciate the Division's efforts in adopting an outpatient hospital fee guideline that is compliant with the Texas Labor Code and with the Medicare fee schedule. One commenter notes that thousands of "fair and reasonable" disputes have added considerable litigation costs to the Texas system due to not having an outpatient fee guideline in place.

Agency Response: The Division agrees the adopted rule for hospital outpatient services is needed and appreciates the supportive comments.

§134.403 and §134.404: In regard to both §134.403 and §134.404, a commenter expresses concern about the significant challenges, short-term impact, costs that payers and vendors are likely to face in implementing the rules, developing new technology, and retaining staff in order to comply with the Medicare-based methodology. Some of the increased administrative costs will ultimately be borne by Texas employers, as well as other system participants.

Agency Response: The Division understands the concerns; however, since 2001, the Labor Code at §413.011 has directed the Division to adopt and implement fee schedules based upon the standardization of the most current reimbursement methodologies, models, and values or weights used by CMS. The Division believes these required changes will result in significant improvements in the Texas workers' compensation system, including fewer fee disputes. Although system costs are ultimately borne by Texas employers, the net change in administrative costs will be offset by reduced disputes and standardized reimbursement methodologies, and other recent system improvements, such as billing and disability management concepts and rules.

§134.403 and §134.404: Some commenters support and recommend the adoption of both §134.403 and §134.404, without changes or with minor modifications. One commenter believes the Division has attempted to give an appropriate weight and balance to the various statutory requirements and with a number of modifications the proposed payment methodologies can be supported. Another commenter supports the Division's effort to review and modify the hospital fee guidelines. Another commenter appreciates the Division's effort in moving the existing fee guideline to a more appropriate reimbursement. Another commenter commends the Division for obtaining various independent reports upon which to base the proposed inpatient and outpatient hospital fee guidelines.

Agency Response: The Division appreciates the supportive comments.

§134.403 and §134.404: Some commenters do not support the PAFs designated in §134.403 and §134.404, stating that high medical costs do not necessarily equal better quality care. One commenter has concerns that if an appropriate balance is not reached, this rulemaking could undermine the intended efforts of House Bill (HB) 2600 (passed by the Texas Legislature in 2001) and HB 7 (passed in 2005) to remedy the situation of unsatisfactory care and soaring medical costs.

Agency Response: The Division agrees that high medical costs do not necessarily result in better quality of care. In setting fees for the non-network

workers' compensation system, the Division must take into consideration all requirements of the Labor Code, including access to and quality of care provided, as well as cost containment and fairness of the overall reimbursement rate. In setting the payment adjustment factors, the Division has balanced these requirements to meet the overall needs of the system.

§134.403 and §134.404: In regard to both §134.403 and §134.404, commenter believes that there is no statutory requirement for the Division to consider what hospitals are being paid by a small commercial insurance company, such as one with one-tenth of one percent market share, and average that in with everybody else. Commenter emphasizes that the payment adjustment factor should relate to costs to assure reasonable access as opposed to paying them comparable to what commercial insurance companies may be paying.

Agency Response: The Division must consider all the requirements of the Labor Code §413.011 in developing and adopting fee guidelines. The Division clarifies that it has not set benchmarks on the business practices of any particular carrier. The Division has considered Medicare reimbursement, historical Texas workers' compensation system reimbursement, data from THA's market survey, the Ingenix market analysis, and stakeholder recommendations in arriving at a payment adjustment factor. In considering the economic indicators of health care

the Division must consider the requirements of the Labor Code in evaluating both the Medicare cost benchmark and the actual experience of the market.

§134.403 and §134.404: A commenter opposes the reimbursement amounts provided by §134.403 and §134.404, stating that unnecessary and extreme fluctuations in reimbursement amounts will only drive employers out of the system. In support of the comment, the commenter references a recent survey of employer participation in the Texas workers' compensation system which resulted in 35.4 percent of non-subscribing employers reporting that they are not in the workers' compensation system because premiums are too high.

Agency Response: The Division disagrees. The adopted rules establish standardized reimbursements on an ongoing basis. This is in sharp contrast to the number of disputed cases resulting from previous per diem and stop loss methodology for inpatient hospital claims and the fair and reasonable reimbursement standard applied to hospital outpatient claims. Premiums are one of many factors employers consider when determining whether or not to subscribe to the workers' compensation system. Claim costs are driven by frequency of medical treatments, cost per treatment and length of disability. Recent system changes have provided carriers with new tools to manage claim costs and outcomes. The adopted Division treatment and return to work guidelines should allow providers and carriers to manage overall claim costs.

§134.403 and §134.404: In regard to both §134.403 and §134.404, a commenter supports adequate payment to providers, but warns that setting a rate too high will have the unintended consequence of driving employers out of the system, negatively impacting the viability of certified health care networks by increasing their costs to levels that result in insurers and employees electing to not participate in networks, and creating a crisis in the Texas system caused by out of control medical costs.

Agency Response: The Division disagrees with the implication that fee guidelines will negatively impact the viability of certified health care networks and create a system crisis. The Division clarifies that these rules generally do not apply to certified worker's compensation networks under Chapter 1305, Insurance Code, and do not apply to political subdivisions contracting directly with health care providers or political subdivisions contracting directly with a health benefits pool established under Chapter 172, Local Government Code, pursuant to Labor Code, § 504.053 (b)(2) and (c)(3). Although the Division has adopted a fee schedule as required by the Labor Code, Labor Code §413.011 (d-1) allows an insurance carrier or the carrier's authorized agent to use an informal or voluntary network, as those terms are defined by Labor Code § 413.015, to obtain a contractual agreement that provides for fees different from the fees authorized under the Division's fee guidelines based on certain requirements.

Labor Code at §413.011 (relating to Reimbursement Policies and Guidelines; Treatment Guidelines and Protocols) establishes the requirements for fee guidelines that are fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. Section 413.011 requires the development of health care reimbursement policies and guidelines that use the most current reimbursement methodologies, models, and values, or weights used by CMS in order to achieve standardization of reimbursement structures. In determining "fair and reasonable" reimbursement levels, the Division must consider several factors because "fair and reasonable" is a balance of all the required components of the Labor Code. Certified network issues and regulations are a separate set of laws and rules under the Workers' Compensation Health Care Network Act, which is codified at Texas Insurance Code Chapter 1305, and is not administered by the Division of Workers' Compensation.

§134.403 and §134.404: In regard to both §134.403 and §134.404, some commenters express concern about the proposed reimbursement rate. One commenter recommends that fee guidelines should reflect a reimbursement rate that is at the lower end of the average payment range for states that have adopted medical fee guidelines and not an average payment such as reflected in the Division's proposal. The commenter asserts that during the 80th Texas

Legislative Session, the Legislature passed House Bill 473, which requires that by the year 2011 out-of-network care will only be able to contract at or above the fee guideline amount. This statutory change will result in a significant increase in medical costs without even factoring in the cost increases included in the proposed Medical Fee Guideline and the Hospital Fee Guidelines. This is the first time in a rule-making process by the Division or the former Texas Workers' Compensation Commission that this is a factor for fee guidelines and there is no other state with a Medicare-based system in which this limitation exists.

Another commenter states that because of recent legislation, the rates set by the Division will become the floor for all network negotiations and the minimum amount at which networks can contract with healthcare providers. The commenter further states that the Division would want to make certain that the floor would reasonably relate to average hospital costs for the workers' compensation book of business. The commenter concedes that since hospitals should be encouraged to go into networks, they should have an incentive to negotiate for those higher rates while making certain that those negotiations occur at a level that doesn't result in raising overall system healthcare prices.

Agency Response: The Division disagrees that the reimbursement rate should be specifically set at the lower end of the average payment range for states that have adopted medical fee guidelines. In setting the guidelines, the Division must consider all aspects of Labor Code at §413.011. The Labor Code establishes the

requirement that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. Section 413.011 requires the development of health care reimbursement policies and guidelines that use the most current reimbursement methodologies, and models, values or weights used by CMS in order to achieve standardization of reimbursement structures. In determining "fair and reasonable" reimbursement levels, the Division must consider several factors because "fair and reasonable" is a balance of all the required components of the Labor Code.

Additionally, although HB 473 has set in place changes that will occur in 2011, the Division is directed to review and revise, if indicated, fee guidelines on a regular basis in accordance with the Labor Code §413.012. Consequently, predicting the impact of this fee guideline upon a future requirement of the Labor Code that requires certification of all networks is premature.

§134.403 and §134.404: In regard to both §134.403 and §134.404, a commenter recommends that the Division fully explore all information in order to implement an accurate and workable fee guideline, including the effect of the newly adopted medical severity DRGs.

Agency Response: The Division agrees that it needs to consider all information available when developing or amending fee guidelines, and to this end it has reviewed the information available and solicited informal comments from

stakeholders prior to proposal. The Division disagrees that additional research is necessary concerning medical severity DRGs, because the Labor Code requires adoption of the most current CMS weights, values, and measures.

§134.403 and §134.404: In regard to the sections adopted in this order, a commenter recommends that the commissioner put together a training team to travel and teach these rules in order for a smooth implementation, stating that it will take collaboration on the part of all system participants to make these changes work.

Agency Response: The Division agrees that partnering with stakeholders is beneficial. The Division will provide training information to facilitate a smooth implementation.

§134.403 and §134.404: For both §134.403 and §134.404, a commenter recommends that the Division develop tools similar to Trailblazer's "Pricer" tools for the Inpatient Prospective Payment System and the Outpatient Prospective Payment System. Many small community hospital and insurance carrier information systems are not equipped to calculate the Medicare payment rate, so "pricer" tools published on the Division's website would allow system participants to operate in compliance with the new rule. In addition, the tools would dramatically reduce the amount of unnecessary disputes that are bound to occur

from errors in calculation with the adoption of a complex reimbursement methodology.

Agency Response: The Division disagrees that unique training tools should be developed by the Division as CMS' tools are readily available at the CMS website, www.cms.gov. In addition, privately-developed software and tools are available and can be customized to meet the individual business needs of system participants.

§134.403(a)(1): A commenter recommends adding the following language to §134.403(a)(1) to provide clarity and reduce potential misinterpretation: "This section applies to medical services provided in an outpatient acute care hospital on or after March 1, 2008. This section does not apply to services paid in accordance with §134.202."

Agency Response: The Division declines to make the requested change because it would be redundant of §134.403(a)(2).

§134.403(a)(1) and §134.404(a)(1): For both §134.403 and §134.404, a commenter requests a postponement of adoption of the proposed acute care hospital fee guideline for 90 days and provides the following basis for the request: bad timing, no reimbursement provision for medical education or bad debts, the appropriateness of outlier payment methodology needs examining, it is

necessary to determine whether 40-percent of commercial billed charges is representative throughout the State of Texas, and the necessity to examine the reimbursement impact of medical severity diagnosis related groups (MS-DRGs).

Agency Response: The Division declines to make the change and notes that the applicability dates for adopted §134.403 and §134.404 are unchanged from proposal. Stakeholders are generally anxious to implement a new inpatient hospital reimbursement system, and prefer a quick transition away from the challenges associated with §134.401. Since hospital outpatient claims are reimbursed on a “fair and reasonable” basis without the benefit of a fee guideline, it is important to implement the APC fee structure without further delay.

Stakeholders will benefit from the certainty of the new reimbursement methodologies: facilities should have few implementation requirements relative to appropriate billing. Although carriers may face more implementation challenges, carriers should have some lag time after the applicability date to process these claims. However, carriers must still meet the requirements of the Labor Code and Division rules to pay, reduce, deny, or determine to audit a claim within 45 days of the receipt of a clean claim from the provider.

§134.403(a)(1) and §134.404(a)(1): A commenter states concern that carriers and vendors may not have sufficient time to complete the necessary system renovations prior to the effective date of the rules as listed in §134.403 and

§134.404, and recommends phasing in the rules to minimize the hardship on those entities that will be required to engage in a significant retooling of their operations in order to comply with the new methodology.

Agency Response: The Division notes that the applicability dates for adopted § 134.403 and § 134.404 are unchanged from proposal. Although carriers may face more implementation challenges, carriers should have some lag time after the applicability date to process these claims. Insurance carriers have assured the Division that they are able to meet the processing requirements of the Labor Code and Division rules to pay, reduce, deny, or determine to audit a claim within 45 days of the receipt of a clean claim from the carrier.

§134.403(b) and §134.404(b): In §134.403(b) and §134.404(b), a commenter recommends that the Division utilize definitions established by the Texas Department of State Health Services in its Chapter 133 rules regarding hospitals, hospital admissions, and associated services.

Agency Response: Under the rules as proposed and adopted, the Division declines to make the change as CMS' definitions prevail if a term is not defined in the Labor Code or the adopted rules.

§134.403(b) and §134.404(b): A commenter believes only Medicare certified hospitals should be allowed to treat and provide medical services to injured

employees in the Texas workers' compensation system because certification indicates that the hospitals have met a high standard of quality health care. The commenter recommends the following language for definition of acute care hospital be added to both §134.403 and §134.404: "Acute care hospital" means an appropriately licensed health care facility that provides inpatient and outpatient medical services to patients who experience acute illness or trauma and are Medicare certified.

Agency Response: The Division declines to make the recommended changes as Labor Code §401.011(22), which defines health care provider, does not require facilities to be Medicare certified. In addition, provisions that might limit the number of facilities available to receive reimbursement pursuant to these fee guidelines might result in a reduction of facilities available to provide care to injured employees, thus, resulting in increased burdens on the workers compensation system.

§134.403(b) and §134.404(b): A commenter recommends inclusion of a definition for "observation period" in both §134.403 and §134.404, and references the Center for Medicare and Medicaid's Manual System, Pub 100-19 Demonstrations, Transmittal 53 which provides information regarding "Extended Stay Services" under "The Frontier Extended Stay Clinic Demonstration Project." Another commenter recommends broadening CMS's definition of "observation" in

the workers' compensation system, which should save money since patients may not need to be admitted to the hospital.

Agency Response: The Division declines to make the changes. Medicare payment policies related to observation are adopted by reference in §134.403(d) and §134.404(d).

§134.403(b)(2) and §134.404(b)(2): A commenter recommends that the definition of implantable devices be amended to include the following language in §134.403(b)(2)(E) and §134.404(b)(2)(E) "and related equipment necessary to operate program and recharge the implantable device." The commenter states this will clarify that implant-related equipment should be billable and reimbursable along with the actual implant devices. The commenter provides examples of items involved in an implant that can vary -- for a neurostimulator or intrathecal drug pump the items could include electrical leads, a battery, a programmer, and a recharger among other items that are not actually implanted but are provided to a patient. The cost of these items could exceed \$3000. These items are typically individually purchased and allowed to be billed and reimbursed separately along with actual related implantable devices. Under the rule's separate cost plus methodology, these items should be billable and reimbursable per individual item. Without rule clarification, this implant-related equipment may not be separately reimbursed despite the intent of the rule.

Agency Response: The Division agrees and the change is made in subsection (b)(2)(E) of the adopted rules. The Division clarifies that equipment necessary to operate, program, and recharge the implantable device are reimbursed separately and the \$1,000 limit is per billed item add-on. The Division additionally has changed subsections (g) of both adopted rules in response to public comment to allow reimbursement for multiple items when a single implantable might exceed the \$1,000 per item cap but not to exceed \$2,000 in add-on's per admission.

§134.403(b)(5) and §134.404(b)(5): A commenter expresses support for the rule provisions both §134.403 and §134.404 that clarify a surgical implant provider's ability to work with hospitals and insurance carriers in providing implantable devices and to bill insurance carriers directly.

Agency Response: The Division appreciates the supportive comment.

§134.403(b)(5) and §134.404(b)(5): Some commenters request that the term and definition of "surgical implant provider" be deleted from the §134.403(b)(5) and §134.404(b)(5), because the Division lacks the statutory authority to recognize implant providers as health care providers. A "surgical implant provider" does not meet the definition of "health care provider" found in Texas Labor Code §401.011, and the Texas Legislature has not recognized "surgical

implant provider" as a stakeholder in the Texas Workers Compensation System as it has with pharmaceutical processing agents under 413.0111. Surgical implant providers do not provide health care and are not involved in the actual treatment of injured employees but act as distributor of implantable devices; therefore, it is inappropriate to attempt to define surgical implant provider as a health care practitioner or health care facility.

Agency Response: The Division disagrees with the comment and declines to make the suggested change. The Division clarifies that the definition for "surgical implant provider" does not expressly define such an entity as being a health care provider. Rather, §134.403(c) and §134.404(c) state that a surgical implant provider is subject to 28 TAC Chapter 133 (relating to Benefits – Medical Benefits) and is considered a health care provider for purposes of §134.403 and §134.404 and Chapter 133. It has been the Department's position in the past that a company that supplies medical equipment is a facility that provides "health care," and thus can meet the definition of "health care provider" under the Labor Code for purposes of Chapter 133. This interpretation was expressed in the adoption order for §133.1 (concerning Definitions for Chapter 133, Benefits - Medical Benefits) published in the Texas Register on March 10, 2000. 25 TexReg 2115 at 2118. Subsequently, the statute changed to include surgical supplies as a form of health care pursuant to Labor Code § 401.011 (19)(F).

§134.403(b)(5) and §134.404(b)(5): A commenter recommends eliminating the option in §134.403 and §134.404 that allows implant makers to bill carriers directly. The commenter states there is no good rationale for allowing them to do that, any more than allowing blood suppliers, suture manufacturers, or anyone else to bill carriers directly. The commenter explains that there is no contract between the implant manufacturer and the carrier so any negotiated discount that a hospital would have negotiated wouldn't apply to the carrier. A commenter states that a carrier has no ability to become a party to the negotiations between a hospital and an implant manufacturer.

Agency Response: The Division declines to make the deletion. Other suppliers may not bill separately since the Division considers payments for the noted services to be bundled in the DRG and APC payments.

In regard to the commenter's concern regarding a discount amount negotiated by a hospital, the Division notes that if the implant provider is the party billing, then the hospital has not purchased the implant, and there would not be a negotiated discount between the hospital and manufacturer or supplier. Additionally, the Division notes that if an implant is being reimbursed separately, then reimbursement should be at the amount the billing facility paid to the manufacturer, plus the permitted add-on amount.

§134.403(d)(2) and §134.404(d)(2): A commenter expresses belief that the rule provisions in §134.403(d)(2) and §134.404(d)(2) allowing Independent Review

Organization (IRO) decisions to take precedence over Division rules and Medicare payment policies is contrary to the intent of the statute which requires that all health care provided to injured employees must be appropriate and medically necessary treatment. Determinations regarding medical necessity must comply with the processes contained in the Texas Department of Insurance and Division rules, including preauthorization, concurrent review, retrospective review, and medical dispute resolution processes. This rule section would allow IRO doctors to ignore Medicare payment policies that address medical necessity and which may be applied appropriately to services that are not specifically subject to prospective medical necessity review as provided in Division rule 134.600(p) and (q) (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care).

Agency Response: The Division disagrees. IROs must consider the Division's adopted treatment guidelines and Medicare payment policies not in conflict with the treatment guidelines. However, IROs must also consider the individual employee's medical needs. IRO decisions take precedence on a case-by-case basis and are based on medical necessity as directed in compliance with the Labor Code.

§134.403(d)(2) and §134.404(d)(2): In regard to both §134.403 and §134.404, a commenter asserts that preauthorization of inpatient hospital services has been

required for many years, but preauthorization has never precluded retrospective review of ancillary services provided during a hospital admission. As an example, the commenter notes that when surgical procedures in addition to those preauthorized are performed, the medical necessity of such procedures has historically been questioned in a retrospective review. The commenter believes that contrary to a recently published Commissioner's bulletin, retrospective review of hospital ancillary services and supplies is permissible under the provisions of the Texas Labor Code and the Division's medical auditing rules.

Agency Response: The Division clarifies that the commenter's concerns related to §134.600 and Commissioner's Bulletin #B-0028-07 are outside the authority of these adopted rules.

§134.403(d)(3) and §134.404(d)(3): In regard to both §134.403 and §134.404, some commenters support the minimal modifications of the Medicare payment methodologies and policies as provided in this section of the rule, stating that retrospective payments and refunds would make payment within the Texas workers' compensation system uncertain and would result in carriers and hospitals incurring costs associated with making additional payments or refunding payments.

Agency Response: The Division agrees these minimal modifications will improve the system.

§134.403(d)(3) and §134.404(d)(3): A commenter suggests that there is a risk of errors and disputes with the proposed rule language in §134.403(d)(3) and §134.404(d)(3), and recommends minimizing opportunities for error and disputes by building some lag time into the regulation, such as California has done in a corresponding provision which requires that changes to components of the Medicare program be adopted within 60 days of the date on which they are effective for Medicare. The commenter recommends that the Division issue a bulletin to enforce the change, so as to avoid the fiasco that occurred in 2005-2006 when CMS and Congress made changes but many provider bills were not re-audited by carriers for payment of the difference.

Agency Response: The Division disagrees. The adopted rules adopt CMS rules by reference. System participants, including the Division, are responsible for monitoring CMS's proposed and adopted changes to Medicare's system. A delay in implementation defeats the standardization required by the Labor Code.

§134.403(e) and §134.404(e): In regard to both §134.403 and §134.404, a commenter believes that additional workers' compensation costs result when a provider or facility is reimbursed more than the actual billed amount. Additionally,

most bill payment systems prevent a payment amount greater than the billed amount as a system accounting check. Additional costs are incurred by stakeholders when manual exception processes or work-arounds must be provided. The commenter makes recommendations to amend the language to read as follows: (e) Reimbursement shall be the lesser of: (1) the billed amount; or (2) the amount for the service that is: (A) included in a specific fee schedule set in a contract between an insurance carrier and a health care provider, if the contract complies with the requirements of §413.011(d-1) of the Labor Code; or (B) if no contracted fee schedule exists that complies with §413.011(d-1) of the Labor Code, the MAR amount under subsection (f).

Agency Response: The Division disagrees and declines to make the change.

The adopted rules are based on CMS' prospective payment system. This system is designed to reimburse an efficient facility at an average cost amount. In some instances the reimbursement is below cost and in other instances the reimbursement is above cost. This system encourages a health care facility to provide services in a cost-efficient manner and provides an opportunity to offset losses from unprofitable cases.

§134.403(f) and §134.404(f): In regard to both §134.403 and §134.404, some commenters state that more paperwork and a higher rate of non-payment make the workers' compensation system more costly to provide care than in the

Medicare system, and that the rule proposals do not meet the statutory obligation to provide fair and reasonable reimbursements. One commenter states that neither Medicare, nor Medicaid, pay their portion of costs, and as a result, hospitals are participating in a business where they have shifted a number of those costs to the commercial and managed care carriers. The commenter states that the inpatient and outpatient rules establish a level of reimbursement that will not be at a level that would be appropriate for the services provided.

Other commenters recommend that the Division follow the direction of other states with a Medicare-based system that do not carve-out implant reimbursement from DRG or APC codes.

Agency Response: The Division disagrees with the comment. In setting fees for the non-network workers' compensation system, the Division must take into consideration all requirements of the Labor Code, including access to and quality of care provided, as well as cost containment and fairness of the overall reimbursement rate. The Division considered market reimbursement as reported by THA and as projected by Ingenix. When setting the payment adjustment factors, above the Medicare rates, the Division has balanced these requirements to meet the overall needs of the system. Although implantables can be reimbursed separately, the payment adjustment factor has been reduced to offset the separate reimbursement. While there are states without a carve-out for

implantables, the number is limited. The majority of workers' compensation systems reimburse separately for implantables at a cost-plus percentage rate.

§134.403(f) and §134.404(f): In regard to both §134.403 and §134.404, some commenters opine that high costs do not necessarily equal better quality care, and that setting rates too high will have unintended consequences of driving employers out of the system. The commenters state that more paperwork and a higher rate of non-payment make the workers' compensation system more costly to provide care than in the Medicare system, and that the rule proposals do not meet the statutory obligation to provide fair and reasonable reimbursements.

Agency Response: The Division agrees that high medical costs do not necessarily result in better quality of care. In setting fees for the non-network workers' compensation system, the Division must take into consideration all requirements of the Labor Code, including access to and quality of care provided, as well as cost containment and fairness of the overall reimbursement rate. The Division considered market reimbursement as reported by THA and as projected by Ingenix. When setting the payment adjustment factors, above the Medicare rates, the Division has balanced these requirements to meet the overall needs of the system. Although implantables can be reimbursed separately, the payment adjustment factor has been reduced to offset the separate reimbursement. While there are states without a carve-out for implantables, the number is limited. The

majority of workers' compensation systems reimburse separately for implantables at a cost-plus percentage rate.

§134.403(f) and §134.404(f): In regard to both §134.403 and §134.404, a commenter opposes the Division's method of determining the appropriate PAFs when based on charges because charge levels vary by facility and by health care systems.

Agency Response: The Division disagrees. The Division did not base the adopted payment adjustment factors on charges. The Division indexed actual workers' compensation reimbursement to Medicare and the commercial market. As a part of the indexing, the Division determined the relationship between billed charges and actual reimbursement when Medicare reimbursement relationships could not be established. Again, the Division considered market reimbursement, Medicare reimbursement and actual workers' compensation reimbursement in setting the adopted payment adjustment factors consistent with the Labor Code requirements.

§134.403(f) and §134.404(f): In regard to both §134.403 and §134.404, a commenter asserts that the statute requires the Division to pay no more than Medicare unless the Division can show that the Medicare population does not have a comparable standard of living to the workers' compensation population,

thereby, justifying that higher payments are necessary to secure reasonable access to quality medical care for injured employees. The commenter states that where there are two populations with an equivalent standard of living, as with managed group health and workers' compensation, the proper method of reimbursement is to pay the lower rate, and not to average the rates by the two benchmark population.

The commenter states that in setting the payment adjustment factor the Division should determine the average costs that hospitals in Texas incur in serving workers' compensation patients and how that compares to 100 percent of what Medicare would pay the hospitals. Commenter states that if the mix of services was such that Medicare payments covered 100 percent or more of the hospital cost, then it would be difficult to determine the public policy rationale for setting a payment adjustment factor higher than 100 percent since the Division would not need to provide for access.

Agency Response: The Division disagrees that workers' compensation reimbursement should be restricted by the standard of living for Medicare patients. The employed population with health care coverage may be more similar to injured employees than the Medicare population. The Labor Code does not designate the Medicare population as the only similar standard of living the Division should consider. Labor Code §413.011(d) states reimbursement should be no more than the fee charged as opposed to the fee paid – “[T]he

guidelines may not provide for payment of a fee **in excess of the fee charged** for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf..." [emphasis added]. In setting the PAF the division has considered the reimbursement relationship between Medicare and the commercial market and the specific need of the Texas workers' compensation system. The consideration of Medicare cost is one of several factors in evaluating the market; however, Medicare cost alone may not be completely reflective of a hospital's relative workers' compensation costs, because of volume, service mix, and other inherent differences between the Medicare and workers' compensation populations. Consequently, access requirements in the Texas workers' compensation system are dependent on many factors and not just a facility's reported Medicare cost.

§134.403(f) and §134.404(f): In regard to both §134.403 and §134.404, a commenter states that reimbursement under scenario 1 (PAF with no additional payment for implantables) and under scenario 2 (Lower PAF with separate payment for implantables) of the proposed inpatient and outpatient rules would result in less reimbursement than under the current system, specifically under the proposed inpatient rule as it pertains to some of the surgical procedures. Any

reduction in expected reimbursement will have a detrimental effect on facilities and whether or not they make a business decision to participate.

Agency Response: The Division clarifies that in some instances a specific hospital stay may be reimbursed less under the new as compared to the previous rules. Overall the Division anticipates an increase in reimbursement for inpatient care and a slight decrease in overall reimbursement for outpatient care. Each facility will have to make business decisions regarding the provision of care in the Texas workers' compensation system.

§134.403(f)(1): A commenter recommends an outpatient PAF of 265 percent of the Medicare APC, with implants carved-out and paid at 65 percent of billed charges in addition to the payment of the APC, and the Medicare outlier calculation.

Another commenter recommends 250 percent of Medicare, since ambulatory surgical centers are currently paid in the system at 213.3 percent of Medicare, and a hospital's costs are recognized by Medicare to be significantly higher than that of an ASC.

Another commenter recommends 185 to 200 percent, rather than 130 percent of Medicare for the implant carve-out PAF with implantables to be paid at cost plus 10 percent, not to exceed \$1000. The commenter says this would

allow hospitals to recover costs while also ensuring access to quality medical care and effective cost control.

Agency Response: The Division declines to make a change. The payment adjustment factors are based on historical workers' compensation reimbursement and comparisons to Medicare and the commercial market, including health maintenance organizations, preferred provider organizations, point of service plans, and commercial indemnity plans. The Division also considered the range of recommendations provided by stakeholders while the Division was soliciting input regarding potential reimbursement options. The adopted payment adjustment factors are well within this range and are reflective of the historic workers' compensation reimbursement, Medicare reimbursement, and current market reimbursement. The reimbursement for ASCs is currently based on the ASC group classifications model, and the ASC payment adjustment factor has no direct relationship to the APC reimbursement payment adjustment factor.

§134.403(f)(1): A commenter recommends rule language that establishes a single PAF for hospital outpatient services at 122 percent of Medicare, stating that this rate will cover the costs associated with providing health care to injured employees in an outpatient setting. The commenter lists statutory requirements for a reimbursement rate, and says that the recommended PAF meets them. The commenter asserts that a higher PAF is not justified by any administrative

costs associated with workers' compensation claims, and he notes that as of January 1, 2008, when electronic billing will be allowed, the claim submittal process for workers' compensation claims should not impose greater administrative costs on hospitals than the claim submittal process for Medicare claims. The commenter concludes that the cost, including bad debt, of billing and collecting co-payments and deductibles in Medicare, which does not exist in workers' compensation, exceeds the cost of the preauthorization process in workers' compensation.

Agency Response: The Division disagrees. As noted previously, the adopted PAFs fill the requirements of the Labor Code and provide appropriate reimbursement for facilities.

§134.403(f)-(g) and §134.404(f)-(g): In regard to both §134.403 and §134.404, a commenter states that while theoretically helpful to hospitals in a limited capacity one percent of the time for cases outside the norm, the Medicare outlier provision is simply not a solution that ensures adequate reimbursement for device related cases, or other higher cost cases that fall within the norm. The commenter states Medicare reimbursement levels are often inadequate, at least in part, because the payment methodology does not account for the costs associated with acquiring and billing for high-tech devices; ordering, processing, storage, accounting, collections, etc. While Medicare reimbursement does not

account for these costs, commenter believes a thorough understanding and appreciation of these issues and costs is imperative in this discussion in order to draft meaningful solutions.

Agency Response: The Division agrees that a thorough understanding of the issues and costs relative to implantable devices is important in determining a fair and reasonable reimbursement rate for the workers compensation system. The workers compensation patient mix is different than the Medicare patient mix. Musculoskeletal injuries are the predominant diagnosis in the workers' compensation system. Although these types of injuries are present in the Medicare system, other age related diagnoses are prevalent in the Medicare system. Having access to surgically implanted devices for procedures related to these musculoskeletal injuries is crucial in facilitating appropriate and timely treatment and improving return to work outcomes. The costs of surgically implantable devices included in the Medicare DRG system may not fully recognize the costs of specific surgically implantable devices critical for the workers compensation patient mix. As a result the Division has attempted to assure access to and adequate reimbursement for surgically implanted devices by establishing a methodology that identifies and reimburses for the actual cost of the implantable. Additionally, the Division agrees that there are administrative costs associated with ordering, processing and maintaining inventory of these surgically implantable devices. These costs are generally addressed in the add-

on allowance for separately billed and reimbursed implantables. When not reimbursed separately these costs and related reimbursements are bundled in the DRG payment and adjusted by the adopted PAF.

§134.403(f)-(g) and §134.404(f)-(g): A commenter opines that both §134.403 and §134.404 deviate from strict Medicare policies in order to meet other statutory goals of establishing fees that are fair and reasonable and designed to ensure continued access to quality care along with appropriate medical cost control. The commenter believes that in order to ensure appropriate patient access is maintained, the Division is well within these statutory provisions to adopt rules that deviate from strict Medicare policy. Commenter cites previously adopted §134.402, Ambulatory Surgical Center Fee Guideline, that utilizes a PAF of 213.3 percent of Medicare, and provides for the additional and separate reimbursement of surgically implanted devices including those that are paid for separately by Medicare and those “bundled” in the facility payment.

Agency Response: The Division agrees.

§134.403(f)-(g) and §134.404(f)-(g): Some commenters oppose the proposed PAFs in §134.403 and §134.404, stating that Medicare already adjusts for inflation and implant costs in their singular APC or DRG reimbursement amount.

Agency Response: The Division disagrees that the payment adjustment factors are inappropriate. The Division has considered the DRG and APC methodologies as required by the Labor Code and adopts a minimal modification to meet the specific needs of the Texas workers' compensation system with regard to patient access to reasonable and necessary medical care and fair and reasonable reimbursement for facilities.

§134.403(f)-(g) and §134.404(f)-(g): In regard to both §134.403 and §134.404, a commenter opines that device manufacturers have been able to participate in a system in which price is of little consequence. The Division's proposal aggravates the problem because hospitals can receive more money for more expensive implants - up to \$1000. The commenter states carve-outs encourage abuse, over utilization of implantable devices, and increase costs unnecessarily to the workers' compensation system, while hospitals can recoup the cost of a device regardless of what a device manufacturer charges, and with no incentives to control costs of implants. In this type of payment structure, hospitals willingly give all control to the physicians in choosing the implant, whereas with Medicare patients, hospitals are much more active in the decision making process to encourage cost control.

Agency Response: The Division acknowledges the commenters' concerns. The Division, however, disagrees that price is of little consequence to a

purchaser of implant devices. For instance, the 110th Congress is currently considering S. 2221, the *Transparency in Medical Device Pricing Act of 2007*, filed on October 23, 2007. This proposed federal legislation would require medical device manufacturers, as a condition of receiving direct or indirect payments under Medicare, Medicaid, and CHIP, to submit to the Secretary of Health and Human Services, on a quarterly basis, the average and median sale prices for all implantable medical devices used in inpatient and outpatient procedures. Thus, this demonstrates that the cost of implantable devices is not only a specific concern to the workers' compensation system, but a significant concern in other health care payor systems. As such, a facility is concerned with its time and value of money through the purchasing and collection processes. Physicians are responsible for determining the medically appropriate implantable device. The Division plans to closely monitor implantable device costs. This may include a data call to capture specific implantable information, such as the invoice cost and facility charge. In addition, the Division may request other specific implantable information, such as the lot number, model number, serial number of the device, or other identifier used by a manufacturer. The latter identifiers are consistent with medical device tracking requirements imposed on a manufacturer when tracking is ordered by the Food and Drug Administration for a class II or class III medical device pursuant to 21 U.S.C. § 360i (e) and 21 C.F.R. § 821.1 *et.seq.*

§134.403(f)-(g) and §134.404(f)-(g): In regard to both §134.403 and §134.404, some commenters cite the RAND study of California's workers' compensation system, which is the only state that utilizes a Medicare-based payment system that includes carve-outs. The study found no cost-based justification for the carve-out. As a result of their finding, in 2003, the California Commission on Health and Safety and Workers' Commission proposed eliminating the carve-out, which was estimated to save the system \$60 million annually.

Agency Response: The Division has reviewed the RAND study. The state of California took no action as a result of the RAND recommendations and continues to pay separately for surgically implanted devices related to specific DRGs. The RAND study included other recommendations that would allow separate reimbursement of surgically implanted devices which included revaluing the DRG relative weights. The Division adopts a variation of this re-weighting recommendation by establishing a lower payment adjustment factor when implanted devices are billed and reimbursed separately.

§134.403(f)-(g) and §134.404(f)-(g): Some commenters suggest that allowing hospitals and third parties to carve-out reimbursement for implantable devices in §134.403 and §134.404 could lead to fraud, and that neither the Division nor the Department have the resources or expertise to investigate and prosecute

medical device makers, suppliers, or doctors who participate in kickback schemes.

Agency Response: The Division acknowledges the commenter's concerns.

The Division can and has cooperated with other health care payor systems and governmental entities to pursue suspected fraud.

§134.403(f)-(g) and §134.404(f)-(g): In regard to both §134.403 and §134.404, a commenter observes that prospective payment systems are useful tools in controlling medical costs because the tools provide incentives for hospitals to be prudent in purchasing goods and services, including implants. Hospitals treat large volumes of Medicare patients without a carve-out for implants. There is no reason to believe hospitals cannot or will not treat workers' compensation patients, which comprise approximately two percent of hospital inpatients in Texas, without a carve-out for implants. Ohio, North Dakota, South Carolina and California have Medicare-based payment systems for workers' compensation hospital inpatients. Of the four, only California has a carve-out for some implants.

Agency Response: The Division acknowledges that prospective payment systems can be useful tools in controlling costs. The Division adopts the prospective payment systems as required by the Labor Code with the specific minimal modification to accommodate the needs of the workers' compensation

system. The Division notes that hospitals have consistently stated a reluctance to continue to provide service to workers' compensation patients if payments do not adequately address the high costs of implantable devices. As noted, with relatively few workers' compensation cases, even efficient facilities do not have the ability to recover the costs of expensive implantable through increased volume.

§134.403(f)-(g) and §134.404(f)-(g): Some commenters do not support the proposed PAFs in §134.403 and §134.404, and recommend use of only one PAF.

Some commenters recommend reimbursement rates be set at 120 percent of Medicare for both hospital outpatient and inpatient rules respectively.

One commenter says that he arrived at this recommended PAF of 120 percent of Medicare by recognizing the time lapse between the 2005 data and inpatient and outpatient rules taking effect in 2008. The commenter says that he considered what some of the other states had done and felt no evidence existed showing any problem in access or that hospitals had gone under as a result of these rates. Commenter asserts that the 120 percent recommendation gives an adequate cushion.

Other commenters suggests that a single PAF of 120 percent of Medicare would provide a good starting point for HB 473 in setting the statutory floor in

2011, and notes that no other states with a Medicare based system have such a limitation.

Agency Response: The Division disagrees. The adopted PAFs fulfill the requirements of the Labor Code and provide appropriate reimbursement for facilities. Although 120 percent of Medicare is used in the California workers' compensation system, it is not necessarily a target for the Texas workers' compensation system. Other states have higher reimbursement rates. In all cases each state sets a rate based on its own specific legislative and administrative requirements.

The Division notes that although HB 473 requires all informal and voluntary networks to be certified beginning in 2011, the fee guidelines should be reviewed and/or revised prior to that date. When the Division reviews these rules, it will establish fees that are appropriate for system requirements at that time. The Division clarifies it has adopted a fee schedule as required by the Labor Code, and the Labor Code currently allows providers and carriers to negotiate non-network fees above or below the guideline.

§134.403(f)-(g) and §134.404(f)-(g): A commenter says that if two PAFs are adopted for §134.403 and §134.404, the hospital should be limited to billing for the lower of the two net prices.

Agency Response: The Division disagrees. The suggested approach would defeat the purpose of insulating facilities from providing high cost surgical implants and threaten injured employee access to services requiring these devices.

§134.403(f)-(g) and §134.404(f)-(g): Some commenters say that the proposed PAFs and implant provisions §134.403 and §134.404 violate Labor Code §413.011(a), which requires that the Division adopt the most current reimbursement methodologies, models, and values or weights used by CMS with "minimal modifications." Such PAFs and separate payments for implants are much more than a minimal modification and there is no data to justify such a major modification to ensure the quality of medical care and to achieve effective medical cost control as required by §413.011(d).

Agency Response: The Division disagrees. The Division adopts the most current Medicare reimbursement methodologies as required by the Labor Code. Specifically, the Division adopts minimal modifications to reimbursement methodologies to meet the occupational injury requirements as noted in §413.011(a). In accordance with §413.011(b), it is also clearly within the authority of the commissioner to develop one or more conversion factors or other payment adjustment factors in determining the appropriate fees. The Division adopts payment adjustment factors that provide appropriate reimbursement for

facilities and assure injured employee access to procedures requiring surgically implanted devices.

§134.403(f)-(g) and §134.404(f)-(g): A commenter states that having a carve-out for implants in §134.403 and §134.404 violates the Texas Labor Code. The commenter references the proposal preamble as stating that implants can constitute 25 percent of the total cost which is significant. The commenter believes that when a pass-through of those costs is allowed there is no effective medical cost control because hospitals will have no incentive to negotiate implant prices and physicians will have no reason to consider the cost-effectiveness of one program over another. The commenter states that the carrier is left with no option but to pay whatever the implant manufacturer chooses to charge.

Agency Response: The Division disagrees the option of separate reimbursement of implantables violate the Labor Code. The Division has set payment adjustment factors that balance the requirements §413.011, including the requirement to achieve effective medical cost control. The Division, in adopting a lower conversion factor for cases when implantables are billed separately, has recognized the need for payment restraint. Although implantables may be reimbursed separately, there is no added incentive to maximize charges to reach a stop loss threshold. This is a significant cost containment measure compared to the previous rule. The Division notes that

implant costs are a significant concern in the entire health care industry and are not limited to the Texas workers' compensation system. Consequently, the Division is committed to monitoring the use and cost of implantables on an ongoing basis.

§134.403(f)-(g) and §134.404(f)-(g): A commenter says that because implants affect 25 percent of the costs for many cases the Division cannot reasonably regard the carve-out provisions in §134.403 and §134.404 as a minimal modification of Medicare payment policies. Commenter states that Medicare does not carve out implants from the DRG payments.

Agency Response: The Division clarifies that §413.011(a) directs the Commissioner to adopt health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems with minimal modifications to those reimbursement methodologies as necessary to meet occupational injury requirements. The Labor Code does not limit the Division to the use of Medicare reimbursement structures. In developing these rules the Division's research indicates that most worker's compensation systems and group health plans reimburse separately for implantables.

§134.403(f)-(g) and §134.404(f)-(g) In regard to both §134.403 and §134.404, a commenter recommends setting the payment adjustment factor as necessary to account for the implants but eliminating the option of the cost pass-through. A commenter states that there are too many possibilities for improper business practices with the pass-throughs, both between implant makers and physicians and implant makers and hospitals. The commenter states that the carriers and the Division do not have the means to either detect those improper business practices or to deter them.

Agency Response: The Division declines to make the change. By setting dual conversion factors and allowing separate reimbursement for implantables the Division has developed a methodology that assures access to implantable devices by injured employees. Although a single conversion factor could be adopted to, on average reimburse appropriately for the workers' compensation system, an average rate would not cover cost for many extremely expensive implantables. Without a mechanism to insulate facilities from these potential losses, an injured employee's access to necessary medical care is compromised.

§134.403(f)-(g) and §134.404(f)-(g): In regard to §134.403 and §134.404, a commenter suggests there is no data to support higher PAFs for outpatient care as opposed to inpatient care.

Agency Response: The Division disagrees. The payment adjustment factors are based on historical workers' compensation reimbursement and comparisons to Medicare and the commercial market, including health maintenance organizations, preferred provider organizations, point of service plans, and commercial indemnity plans. The adopted payment adjustment factors are reflective of this historical differential and current market reimbursement.

§134.403(f)-(g) and §134.404(f)-(g): A commenter opines that §134.401 lacked incentives for hospitals to control costs, and in §134.403 and §134.404, neither the PAFs nor the carve-outs for implants are the appropriate incentives to control costs of implants.

Agency Response: The Division disagrees. The adopted rules are based on the CMS prospective payment systems. The majority of services covered by these two rules will be provided without separate reimbursement for implantables. There is a very direct incentive for facilities to provide services in a cost efficient manner in order to develop a profitable workers' compensation product line. Although implantables may be reimbursed separately, the same prospective payment concepts apply to the remainder of an admission, which is reimbursed at a reduced rate. Since workers' compensation volume for most facilities is relatively low, the necessity to be efficient on every workers' compensation admission is intensified.

§134.403(f)(1) and §134.404(f)(1)(A)-(B): Some commenters make recommendations in regard to §134.403(f)(1) and §134.404(f)(1)(A)-(B). To account for bad debt amounts, a commenter recommends a PAF for non-teaching hospital outpatient services of 202 percent with the inclusion of implantables, or 131 percent with implantables paid separately for non-teaching hospital outpatient services; and the commenter recommends a PAF for non-teaching hospital inpatient services of 144 percent with the inclusion of implantables, or 109 percent with implantables paid separately for non-teaching hospital inpatient services. In regard to inpatient services, the commenter also recommends that the PAF be increased to account for the application of the Medicare transfer rules or that both hospitals be paid the full DRG amount.

Agency Response: The Division disagrees with the recommended payment adjustment factors. Bad debt is paid outside the base methodology and is a part of the cost report reconciliation process, which the Division has not adopted. Additionally, bad debt in the workers' compensation system is limited to those situations that are non-compensable or are not related to the compensable injury and as such are not included in system costs. The patient is responsible if it is determined the claim is not compensable or not related to the injury and the patient and/or patient's group health insurance may be liable for facility services. In regard to the comment concerning Medicare transfer rules, the Division notes

that paying both facilities the full DRG in transfer situations would result in significant overpayment for a stay and is contrary to the effective medical cost control provisions of the Labor Code.

§134.403(f)(1)(A)-(B) and §134.404(f)(1)(A)-(B): A commenter expresses appreciation for the effort by the Division to gain the best and most current information available on hospital costs and payments, and its efforts to consider this data and analysis in the establishment of the proposed PAFs in §134.403 and §134.404. The commenter believes it is particularly important that the Division consider the reimbursement amounts that hospitals competitively negotiate with commercial health plans because these reimbursement amounts reflect the market value of hospital services. The commenter further asserts the establishment of payment rates for workers' compensation services that are consistent with other non-governmental payers assures that employers are not cross-subsidizing inadequate workers' compensation payment rates through increases in their nonworkers' health insurance premiums.

Agency Response: The Division appreciates the supportive comments.

§134.403(f)(1)(A)-(B) and §134.404(f)(1)(A)-(B): To appropriately reflect the added costs for teaching hospitals, a commenter recommends setting PAFs at 212 percent of Medicare with inclusion of implantables, or 137 percent with

implantables paid separately for teaching hospital outpatient services. Another commenter recommends setting PAFs for teaching hospital inpatient services at 151 percent of Medicare with inclusion of implantables, or 114 percent with implantables paid separately.

Agency Response: The Division disagrees with the recommendations. The Division determines that additional adjustments should not be made to the payment adjustment factors. Direct medical education is paid outside the base methodology and is a part of the cost report reconciliation process, which the Division has not adopted.

§134.403(f)(1)-(2) and §134.404(f)(1)-(2): Some commenters have various recommendations and questions related to what is contained within the calculations of both §134.403 and §134.404. The commenters ask if examples of the reimbursement calculations will be provided, and request clarification regarding device dependent procedures when they are incorporated into the Medicare payment rates.

Agency Response: The Division declines to provide calculation examples in the adopted rules. The adopted rules adopt Medicare's most current reimbursement methodologies. The Division will provide system participants with training materials facilitating implementation.

§134.403(f)(1)-(2) and §134.404(f)(1)-(2): In regard to both §134.403 and §134.404, a commenter asks if insurance carriers will be able to calculate the payments accurately as it may increase their administrative burden, and suggests this may actually increase the amount of medical fee disputes. Another commenter states that several carriers operating in several states where the outlier methodology is used do not have a problem applying it.

Agency Response: Both carriers and facilities are required to comply with the adopted rules when applicable to specific service dates. This includes the requirements of §133.240 (regarding Medical Payments and Denials) to take final action on a complete medical bill, or determine to audit the medical bill not later than the 45th day after the carrier received a complete medical bill. The Division has been assured by carriers throughout the rule development and public comment periods that carriers will calculate and make payments accurately in accordance with the adopted rules.

§134.403(f)(1)-(2) and §134.404(f)(1)-(2): Some commenters address bad debt in regard to both §134.403 and §134.404. One commenter states that although technically there is no bad debt related to co-pays and deductibles in the workers' compensation system, every time a service is considered a non-compensable injury, upon review it becomes bad debt. Other commenters note that payments for direct medical education (e.g., teaching hospitals) and bad

debt allowance are reimbursed separately from the Medicare base rate, and both factors have significant impact on commenter's health care system. The commenters recommend the PAFs be appropriately increased to account for hospitals' bad debt, medical education payments to teaching hospitals, and other costs of separately billed pass-through items that are supplemental payments made by the Medicare fiscal intermediary.

Agency Response: The Division declines to make changes. Bad debt and direct medical education are paid outside the base methodology and are a part of the cost report reconciliation process, which the Division has not adopted. Additionally, as one commenter notes, bad debt in the workers' compensation system is limited to those situations that are non-compensable or are not related to the compensable injury. As such, it is not included in system costs. The patient is responsible if it is determined the claim is not compensable or not related to the injury and the patient and/or patient's group health insurance may be liable for facility services.

§134.403(f)(1)-(2) and §134.404(f)(1)-(2): In regard to both §134.403 and §134.404, a commenter opposes pass-through reimbursements of Medicare as they apply to payments for bad debt and teaching schools because these Medicare payments amount to federal subsidies of hospitals that treat Medicare patients. Further, "bad debt" in the Medicare system is associated with co-

payments and deductibles that Medicare patients fail to pay. There is not a provision for the payment of co-payments or deductibles in the Texas workers' compensation system. Additionally, no provision exists in the Texas workers' compensation system to reimburse teaching hospitals for their costs that are related to training and teaching student doctors. The Texas Labor Code only provides for the payment of costs associated with reasonably required and medically necessary health care treatment.

Agency Response: The Division agrees that the Labor Code does not provide for pass-through reimbursements to cover bad debt or teaching schools. For this reason, the Division has adopted CMS's base methodology but not parts related to the cost report reconciliation process that address bad debt and direct medical education.

§134.403(g) and §134.404(g): Some commenters support the implant carve-out approach in §134.403 and §134.404, and offer varying recommendations for tightening the rule language. The commenters state that with the additional rule language recommendation to the definition of an implantable, it will be well understood that each individual item that is implanted and the associated elements to make the device function appropriately (e.g., batteries, programmers, rechargers, etc.), is paid separately.

Agency Response: The Division appreciates the supportive comments and notes changes are made in subsection (b)(2)(E) of the adopted rules. The Division clarifies that equipment necessary to operate, program and recharge the implantable device are reimbursed separately and the \$1,000 limit is per billed item add-on. The Division additionally has changed subsections (g) of both adopted rules in response to public comment to allow reimbursement for multiple items when a single implantable might exceed the \$1,000 per item cap but not to exceed \$2,000 in add-on's per admission.

§134.403(g) and §134.404(g): A commenter recommends the addition of the words "per billed item" be added to the 10 percent reimbursement for implantables, capped at \$1000, in §134.403(g) and §134.404(g). This will allow the cap to apply to each individually billed item rather than cumulatively. Commenter additionally recommends that the cap be raised to \$3000 to ensure that acquisition costs are adequately covered.

Agency Response: The Division agrees with the inclusion of "per billed item." The words "per billed item add-on" have been added to subsections (g) of the adopted rules to clarify that the 10 percent reimbursement for implantables applies individually to items billed separately. The Division disagrees to raising the cap per billed item. However, a cap of \$2,000 is added to the adopted rules

to discourage unbundling of items that exceed the \$1,000 proposed per billed item cap.

§134.403(g) and §134.404(g): A commenter supports the rule proposal approach with implantables in §134.403 and §134.404, because it will reduce the number of disputes over payment for implants; however, the commenter suggests the Division consider whether it may be preferable to establish one clear method for reimbursement for implantables.

Agency Response: The Division appreciates the supportive comments; however, believes the adopted methodology as changed from proposal is appropriate for the Texas workers' compensation system.

§134.403(g) and §134.404(g): A commenter suggests that §134.403(g) and §134.404(g), as proposed, exclude any implantable therapy for pain, such as intrathecal infusion systems and neuromodulation techniques, which cost substantially more to manufacture than the proposed upper limit of \$1000.

Agency Response: The Division clarifies that the rules do not limit the cost of an item, but limit the add-on reimbursement to 10 percent of the item's cost, or \$1,000, whichever is less. The Division additionally has changed subsections (g) of both adopted rules in response to public comment to allow reimbursement for multiple items when a single implantable might exceed the \$1,000 per item cap.

§134.403(g) and §134.404(g): A commenter seeks specific clarifications regarding the separate billing of implants in §134.403(g) and §134.404(g). How does the Division believe carriers will specifically determine which payment adjustment factor to apply to the bill without this information or indication under the current proposal? The commenter requests the Division to briefly describe the envisioned flow of this process.

Agency Response: The Division agrees that identifying reimbursement methodologies is important to the successful implementation of the adopted rules. The Division is currently investigating the use of field 80 on UB-04 and the use of the billing note in the ANSI X12 837i transaction set. Specific guidance regarding this process will be available through the Division's outreach and implementation efforts subsequent to the adopted rules.

§134.403(g) and §134.404(g): Some commenters recommend deletion of §134.403 (g) and § 134.404 (g). Another commenter recommends eliminating the option for implant makers to bill carriers directly. The commenter says that there is no good rationale for allowing them to do that, any more than allowing blood suppliers, suture manufacturers, or anyone else to bill carriers directly. The commenter explains that since there is no contract between the implant manufacturer and the carrier, any discount negotiated by a hospital would not

apply to the carrier. The commenter also notes that a carrier does not have the ability to become a party to the negotiations between a hospital and an implant manufacturer. Some of the commenters recommend that if implants are allowed to be billed separately the rule should require both the facility and implant provider bill to be submitted on UB-04 forms, and submitted concurrently.

Agency Response: The Division declines to make the deletion. The Division clarifies that separate billing for implantables by an implant provider should be submitted on a UB-04 form, and suggests that it is impractical to have the facility and implant provider to submit the bills concurrently. Other suppliers may not bill separately since the Division considers payments for the noted services to be bundled in the DRG and APC payments.

In regard to the commenter's concern regarding a discount amount negotiated by a hospital, the Division notes that if the implant provider is the party billing, then the hospital has not purchased the implant, and there would not be a negotiated discount between the hospital and manufacturer or supplier. Additionally, the Division notes that if an implant is being reimbursed separately, then reimbursement should be at the amount the billing facility paid to the manufacturer, plus the permitted add-on amount.

§134.403(g) and §134.404(g): A commenter recommends that in the event that implants are allowed to be billed separately, that §134.403 and §134.404 be

amended to require a hospital to include a code on their medical bill that identifies the method being used to bill for an implantable device. Without such a code, the implantable device could result in unintentional duplicate payment.

Another commenter states there is no obvious way for a hospital to indicate to a carrier on the UB-04 billing form whether or not a separate bill for the implants will be coming later from the implant manufacturer, and notes that carriers will not know whether to reimburse the hospital at the higher or lower rate. The commenter states the model in the proposed rules create the potential for significant confusion in the billing and reimbursement process. Requiring that the bills be submitted together and in a consistent billing format will alleviate some of these concerns. Another commenter expresses concern of the administrative issues associated with supplying implant invoices, such as the time factor with reconciling the claim, adjudicating a claim, and adding to the complexity of reimbursement.

Agency Response: The Division clarifies that the billing methodology will be identified in both the eBilling and paper billing processes. Specific guidance regarding this process will be available through the Division's outreach and implementation efforts subsequent to the adopted rules. If separate reimbursement for the surgically implanted device is sought, the instructions will instruct the facility to communicate whether the facility or if an implant provider is

sending the invoice to the insurance carrier. For this reason the Division declines to make the change requiring bills to be submitted together.

§134.403(g) and §134.404(g): In regard to both §134.403 and §134.404, a commenter suggests that additional documentation on the billed implant should be specific down to the implant serial number so that this information can be adequately tracked and to provide for sufficient audit opportunity. At a minimum, this should include the invoice, the operative report, and the hospital inventory sheet.

Agency Response: The Division declines to require additional documentation. The Division will closely monitor implant costs. This may include a data call to capture specific implantable information, such as the invoice cost and facility charge. In addition, the Division may request other specific implantable information, such as the lot number, model number, or serial number of the device or other identifier used by a manufacturer. The latter identifiers are consistent with medical device tracking requirements imposed on a manufacturer when tracking is ordered by the Food and Drug Administration for a class II or class III medical device pursuant to 21 U.S.C. § 360i (e) and 21 C.F.R. § 821.1 *et.seq.*

§134.403(g) and §134.404(g): In response to both §134.403 and §134.404, a commenter expresses concerns about previous reimbursement methodologies.

The commenter states that the previous reimbursement methodologies resulted in payment delays. The commenter states that anything the commissioner would do in terms of setting up rules that provide an opportunity to dispute the fees, to challenge either the payment mechanisms, or to request further information to be provided creates an environment where the hospital then is really in a position to have to continue to defend or support the charge and provide additional information.

Agency Response: The Division appreciates the commenter's concern. The Division believes that the certainty of the adopted prospective payment methodologies will ultimately reduce conflicts over reimbursement. As the rules allow separate reimbursement for implantables, mechanisms for auditing and monitoring this payment option are a necessity. Since no specific triggers are initiated based on charges, payment conflict should be minimized.

§134.403(g) and §134.404(g): In regard to both §134.403 and §134.404, a commenter recommends the "administrative expense fee" paid to the hospital when implants are paid for separately should be no more than \$25, because there is no justification for paying the lower of 10 percent of the implant's cost or

\$1000 simply because the hospital chooses to have the implants paid for separately.

Agency Response: The Division declines to make the change. The Division clarifies that the add-on for separate reimbursement of 10 percent of invoice cost or \$1,000, whichever is less, is based upon the entity requesting reimbursement for the separately reimbursed implantable. However, a cap of \$2,000 is added to the adopted rules to discourage unbundling of items that exceed the \$1,000 proposed per billed item cap. If a surgical implant provider bills separately for the surgical implant, the provider is entitled to the add-on reimbursement. In this situation the facility should receive no additional reimbursement for the items billed separately by the surgical implant provider.

§134.403(g)(1) and §134.404(g)(1): Some commenters suggest clarification in both §134.403(g)(1) and §134.404(g)(1). The commenters recommend the rules clarify that an implant manufacturer may not bill separately for implants, and suggest the proposal preamble and proposed rule language are in conflict. One commenter states that allowing the hospital to “bill separately” for the implants and the hospital services themselves, and, thereby, collect an administrative expense fee of up to \$1,000 in addition to the cost of the implants adds nothing but additional cost to the workers' compensation system. The commenter states a savvy hospital could increase its revenues and impose additional costs on the

workers' compensation system simply by breaking a bill into two parts when there is no reason to do so, other than to collect the "administrative expense fee" authorized by this rule.

Agency Response: The Division declines to make the change, as the rules intend for the option of separately implanted devices to be billed either by the facility or by the surgical implant supplier as defined in §134.403(b)(5) and §134.404(b)(5). The Division clarifies that the facility will submit only one bill. The PAF for facility reimbursement is determined by the facility based on the separate reimbursement of implantables. This determination will likely be documented in a specified field on the UB-04. When a facility chooses the lower PAF and separate implantable reimbursement option, the facility's bill would include the invoices for the separately implantable devices for which it was seeking separate reimbursement and the appropriate invoice certification required by §134.403(g)(1) and §134.404(g)(1). However, if an implant provider is billing for the implantable device, the carrier would receive two bills. The carrier would receive a bill from the facility for treatment and services provided to the injured worker that are unrelated to the cost of the implant. The carrier would receive a bill from the surgical implant provider specific to the implant that includes the required invoices and certifications. Reimbursement for the implantable and the appropriate add-on amount will be made to the entity that submitted the UB-04 with the required invoice and certification.

§134.403(g)(1) and §134.404(g)(1): A commenter express concern with the certification statement in §134.403(g)(1) and §134.404(g)(1), and says that the certification will conflict with the charges reflected on the facility's charge master and itemized statement.

Agency Response: The Division clarifies that the required certification is related to the invoice amount for which the facility or implant provider is seeking reimbursement. It is not the intent of the Division that certification reconcile a facility's charge master and the requested cost plus reimbursement for implantables.

§134.403(g)(1)-(2) and §134.404(g)(1)-(2): A commenter supports the provisions in §134.403(g)(1)-(2) and §134.404(g)(1)-(2) that allow for surgical implant providers, often used by facilities that do not have the infrastructure required to acquire, to obtain prior authorization for, and to secure payment for implantable devices, and to bill carriers directly for implants.

Agency Response: The Division appreciates the supportive comment and agrees that the Division has attempted to assure access to and adequate reimbursement for surgically implanted devices by establishing a methodology that identifies actual facility costs.

§134.403(g)(1)-(2) and §134.404(g)(1)-(2): In regard to both §134.403 and §134.404, a commenter states that the DRG really does not turn on the specific charges. The commenter states that the way to audit a bill in a DRG system is to basically determine whether the medical records support the coded DRG.

Agency Response: The Division notes that in a prospective payment system reimbursement is not generally dependent on charges and as such auditing requirements are significantly different than in the previous structure of §134.401.

§134.403(g)(1)-(2) and §134.404(g)(1)-(2): Some commenters recommend amendments to §134.403(g)(1)-(2) and §134.404(g)(1)-(2) which read, "I hereby certify under penalty of law that I have personal knowledge of the cost of the surgical implantable and the following is the true and correct actual cost after consideration of any and all rebates, discounts or any other financial incentives associated with the purchase of the surgical implantable." One commenter states that it appears that the certification is designed to avoid billing fraud; however, the facility and surgical implant provider can avoid the risk of fraud by having an employee that does not have knowledge of the cost sign the certification.

Agency Response: The Division disagrees with the recommendation. The language in §134.403(g)(1)-(2) and §134.404(g)(1)-(2) has been used §134.402 (regarding Ambulatory Surgical Center Fee Guideline) since amendments to that

section were adopted in 2005, and the Division has not seen problems in its application or use.

§134.403(g)(1)-(2) and §134.404(g)(1)-(2): A commenter recommends amended language in §134.403(g)(1)-(2) and §134.404(g)(1)-(2) that reads, “Nothing in this rule precludes a health care facility and insurance carrier from utilizing a surgical implant provider to arrange for the provision of implantable devices. The health care facility and insurance carrier must both agree to utilizing a surgical implant provider to arrange for the provision of an implantable device.”

Agency Response: The Division declines to make the change. Requiring both the facility and carrier to agree to the use of a surgical implant provider would potentially restrict or limit the facility’s ability to make business decisions appropriate to its specific financial situation.

134.403(g)(4): A commenter expresses concern that §134.403 requires payment by the Medical Fee Guideline.

Agency Response: The Division clarifies that the other Division fee guidelines, which include the Medical Fee Guideline, are used only when the corresponding Medicare fee schedule is utilized by Medicare to supplement the OPPS.

§134.403(h) & (i): Some commenters support the inclusion of Medicare's restriction of a specific setting for a service and assert that it is consistent with Section 413.011(d)(1) of the Labor Code.

Agency Response: The Division appreciates the supportive comment.

§134.403(h) & (i): A commenter believes that to obtain preauthorization and negotiate the facility fee for an alternative facility would violate Texas Labor Code Section 413.011(a) since it would constitute a major modification from CMS reimbursement methodologies and models. In addition, commenter states this would tend to delay necessary medical treatment, prolong lost time from work, and encourage fee disputes while the parties negotiate the facility fee, violating the legislative goals outlined in House Bill 7 reforms found in Section 402.021(a & b).

Agency Response: The Division disagrees. The language allows for providers and carriers to mutually agree to an alternative place of service. Although the Division adopts the place of service requirements, there may be instances when both providers and carriers believe an alternative setting may be beneficial to the injured employee. This concept has been in place in §134.402 since 2004 with few problems.

§134.403(i)(1-3): A commenter recommends amending rule language in §134.403(i)(1-3) to read as follows: “(1) The agreement between the insurance carrier and the party that requested the alternative facility setting shall be submitted in the form and manner prescribed by the Division. (2) An agreement for an alternative facility setting may be revised during or after preauthorization by written agreement of the insurance carrier and the party that requested the alternative facility setting. (3) In the event of a revision of an agreement, the revised agreement shall be submitted in the form and manner prescribed by the Division.”

Agency Response: The Division disagrees that a form is necessary to facilitate this process. The Division has outlined the requirements of the agreement so that no Division mandated form is necessary. Similar direction is in place for §134.402 with good results.

§134.404: A commenter recommends that the Diagnosis Related Groups (DRGs) list in §134.404 remain open and not limited to the Division's judgment, and allow the medical providers to use the proper DRGs when needed.

Agency Response: The Division clarifies that the Texas workers' compensation system utilizes the most current CMS DRG set without limitation.

§134.404: In regard to §134.404, some commenters support the Division's rule proposal action that removes any stop loss provisions.

Agency Response: The Division appreciates the supportive comments.

§134.404(a)(1): A commenter requests an earlier effective date than March 1, 2008, for the inpatient hospital fee guideline. The basis for this request is the concern about the growing number of "stop loss" bills that are being received by insurers.

Agency Response: The Division disagrees and declines to make the requested change. Although some participants may feel anxious to move away from the reimbursement requirements of § 134.401, an earlier implementation date for the inpatient hospital fee guideline would not allow a sufficient amount of time for system participants to implement the new reimbursement methodologies. Although facilities should have few implementation requirements relative to appropriate billing, carriers need some preparation prior to processing these claims because they will need to meet the requirements of the Labor Code and Division rules to pay, reduce, deny, or determine to audit a claim within 45 days of the receipt of a clean claim from the provider.

§134.404(f): A commenter states that the proposed reimbursement structures of the inpatient rule do not cover the cost of trauma care that is associated with

work related injuries, and this is especially so without a stop loss designation.

The proposed rates will only cover those stays that are not trauma related and with shorter lengths of stay.

Agency Response: The Division disagrees that the adopted rates will cover only those stays that are short stay or are not trauma related. The adopted rules require the use of the most current adopted and effective Medicare reimbursement methodologies. Medicare DRGs, which adjust for severity and recognize the intensity of services for specific patients, will apply to services when these rules become effective. The Division notes that the Medicare prospective payment system generally reimburses based on the average cost for a facility to provide services related to a specific DRG. This average reimbursement includes all cases running the gamut from the least to the most extreme resource-intensive admissions. Medicare reimbursement in general is designed to cover costs and provide a profit for efficiently managed facilities. This concept extends to the outlier methodology, which allows facilities to recover costs for cases that meet the outlier thresholds. Based on this reimbursement structure, which is integral to the prospective payment system, not all admissions will result in a positive margin. The Division adopts PAFs that reimburse at a rate greater than Medicare and provide some protection to facilities on resource-intensive cases. Additionally, facilities have a choice of reimbursement options relative to implantable devices, which insulate facilities from potential losses due

to extremely expensive implantables whose costs may not be fully realized in the Medicare prospective payment system. Although the adopted rules provide for appropriate reimbursement for the system overall, there is no guarantee that a specific facility will realize a positive margin on any specific admission.

§134.404(f)(1)(A)-(B): A commenter recommends setting inpatient hospital PAFs at 175 percent of the Medicare DRG with implants to be paid at 65 percent of billed charges in addition to the DRG amount. The commenter further recommends setting a stop loss provision for claims over \$50,000 in billed charges, and to be paid at 75 percent of the billed charges. Other commenters suggest stop loss provisions at \$100,000 and \$150,000 in billed charges.)

Agency Response: The Division declines to make the change. The payment adjustment factors are based on historical workers' compensation reimbursement and comparisons to Medicare and the commercial market, including health maintenance organizations, preferred provider organizations, point of service plans, and commercial indemnity plans. The Division also considered the range of recommendations provided by stakeholders while the Division was soliciting input regarding potential reimbursement options. The adopted payment adjustment factors are well within this range and are reflective of the historic workers' compensation reimbursement, Medicare reimbursement, and current market reimbursement. The Division has also determined that development of

reimbursement methodologies triggered by a billed charge amount is generally contrary to the concept of effective medical cost control.

§134.404(f)(1)(A)-(B): A commenter is concerned that that the proposed outlier payment is not adequate and hospitals will be reimbursed significantly less than their costs on hospital admissions with extraordinarily long lengths of stay. The commenter does, however, state that he recognizes that the Division's use of the Medicare outlier payment is consistent with the statutory requirements and this type of methodology may overcome some of the complaints expressed by carriers about the existing stop loss provision.

Agency Response: The Division agrees that the adopted methodology is consistent with the requirements of the Labor Code. The Division believes that the prospective payment system and the adopted payment adjustment factors provide appropriate reimbursement for the Texas workers' compensation system. It is unlikely that the adopted reimbursement methodology will provide the exact balance between cost and reimbursement in every case. The prospective payment system allows, on average, efficient hospitals to be profitable but on occasion certain stays may not achieve this standard.

§134.404(f)(1)(A)-(B): A commenter states that a payment adjustment factor is not supposed to guarantee, just like a Medicare DRG, that a hospital makes a

profit or, indeed, even covers its costs on every individual case. The commenter believes that the important issue is whether the system covers hospital costs such that it keeps them financially viable and provides reasonable access to workers' compensation patients.

Agency Response: The Division agrees. The Division believes that the prospective payment system and the adopted payment adjustment factors provide appropriate reimbursement for the Texas workers' compensation system. It is unlikely that the adopted reimbursement methodology will provide the exact balance between cost and reimbursement in every case. The prospective payment system allows, on average, efficient hospitals to be profitable but on occasion certain stays may not achieve this standard.

§134.404(f)(1)(A)-(B): A commenter opines with regard to inpatient reimbursement, the Medicare program is specifically designed for a population that is much different from the workers' compensation population. Medicare's Diagnosis Related Group (DRG) system is premised on the fact that hospitals will have a broad-range of cases and that the higher cost, lower paying DRGs, will be offset by those that are reimbursed at a higher rate. In this case, the workers' compensation system is primarily orthopedic cases and will not have the same breadth of treatments. As a result, hospitals will not have the ability to offset losses through higher-margin DRGs.

Agency Response: The Division agrees and, for this reason, has proposed and, adopted separate reimbursement for implantable devices to insulate facilities from potential losses due to high-cost implantable devices.

§134.404(f)(1)(A)-(B): A commenter recommends PAFs of 165 to 200 percent of Medicare, and 130 to 140 percent as more appropriate since those rates would allow hospitals to recover its costs while also ensuring access to quality medical care and effective medical cost control. The commenter opposes the lower PAFs (108%) for hospital inpatient services, and states it reflects an astonishing reduction from the higher 143 percent PAF provided with out carve-outs for implants. The 40 percent difference between the two PAFs is extreme. Medicare does not calculate 40 percent of its payment rates as a means to cover the cost of implants and neither should the Division. Commenter states it is understandable to have a reduced PAF to provide for implant carve-outs, but this reduction is excessive.

Agency Response: The Division declines to make the change. The differential is an offset to the direct workers' compensation costs attributable to implantable devices. In setting the guidelines, the Division must consider all aspects of Labor Code at §413.011. The Labor Code establishes the requirement that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. Section 413.011

requires the development of health care reimbursement policies and guidelines that use the most current reimbursement methodologies, models, values or weights used by CMS in order to achieve standardization of reimbursement structures. In determining "fair and reasonable" reimbursement levels, the Division must consider several factors, because "fair and reasonable" is a balance of all the required components of the Labor Code.

§134.404(f)(1)(A)-(B): A commenter asserts that the Division needs to determine other costs not related to implants, such as blood, major drugs, sutures, casting, IV fluids and extra respiratory treatment, for other services for a patient that are not factored into the costs incurred by hospitals. The commenter asserts the Division is basically asking hospitals to make a choice to either sacrifice its costs associated with the implants or to sacrifice its costs associated with the hospital stay and the other remaining services provided.

Agency Response: The Division disagrees that costs other than implantable costs are not considered in the Medicare prospective payment system. The DRG reimbursement methodology includes charges for all services provided for a particular DRG. To the extent that the commenter believes the Medicare reimbursement is inadequate, the Division's adopted rules provide reimbursement rates that are greater than those established by Medicare. The overall reimbursement rate of 143 percent of Medicare is within the range of

recommendations by system stakeholders. The Division's adopted rates are more similar to the commercial market as reported by THA than to the Medicare rates. The Division disagrees that facilities must make a choice between implant reimbursement and remaining services. The hospital has the option to be paid at the higher payment adjustment factor or be reimbursed at the lower rate and recover actual costs for the implantable device. The hospital can determine which payment adjustment factor is more favorable by looking at the ratio of overall costs to implantable costs.

§134.404(f)(1)(A)-(B): A commenter notes the Milliman study of payments under the current system represents approximately 115 percent of Medicare, and opines the proposed rates, that are a 23 percent increase, do not support the statutory objectives.

Agency Response: The Division disagrees that the rates do not support the statutory objectives. In setting fees for the non-network workers' compensation system, the Division must take into consideration all requirements of the Labor Code, including access to and quality of care provided, as well as cost containment and fairness of the overall reimbursement rate. In setting the payment adjustment factors, the Division has balanced these requirements to meet the overall needs of the system. The Division notes that facility rates in the Texas workers' compensation system have not changed since 1997. Between

1995 and 2005 cost for hospitals as reported by MedPAC (June 2007 Data Book on Healthcare Spending and the Medicare Program) increased 38%. The increase referenced by the commenter is significantly less than the increase in MedPAC's reported hospital costs.

§134.404(f)(1)(A)-(B): A commenter states the Division offers no justification for increasing the reimbursement for inpatient stays with less than \$40,000 in billed charges, and bases the increase for hospital stays with \$40,000 or more in billed charges solely on amounts paid under commercial health plans. The Division has determined that both Medicare patients and managed care patients satisfy that standard. Thus, in setting the ASC fee guideline, the previous Commission calculated a weighted average market payment that considered amounts paid by both Medicare and commercial health plans, not just amounts paid under commercial health plans.

Agency Response: The Division disagrees. The Division is required to consider all the requirements of the act to establish fair and reasonable reimbursement. In setting the inpatient PAF's the Division considered market rates as projected by Ingenix in a 2005 report sponsored by the former Texas Workers' Compensation Commission, market data provided by the Texas Hospital Association at the request of the Division, Medicare reimbursement, historic Texas workers' compensation system payments, and recommendations by system stakeholders

throughout the rule development process. Specifically, the Division notes that the Milliman report estimated that inpatient bills with charges less than \$40,000 are being paid at approximately 66% of Medicare inpatient rates. If Medicare reimbursement generally is set to on average cover hospitals' costs it follows that 66% of Medicare does not cover these costs or allow a margin for profit. In developing a methodology and subsequently calculating PAF's, it is reasonable for the Division to allow at least the Medicare rate as reimbursement for these claims in its methodology. The adopted PAFs are within the range of the Ingenix market estimates and within the range of recommendations provided by system stakeholders.

§134.404(f)(1)(A)-(B): A commenter recommends that a single PAF for the inpatient hospital fee guideline should be set at 105.9 percent of Medicare. As an alternative to the recommendation of 105.9 percent, the commenter joins other commenters in recommending that the PAF for inpatient hospital care be set at 120 percent of Medicare.

Agency Response: The Division disagrees and declines to make the recommended changes. The adopted PAFs meet the requirements of the Labor Code and establish appropriate reimbursement rates for inpatient services. Setting a reimbursement level of 105.9 percent of Medicare would be nearly an 8% reduction from the estimated workers compensation reimbursement of 115

percent of Medicare. Setting a reimbursement level of 120 percent of Medicare would be less than a 5 percent increase from the estimated workers compensation reimbursement of 115 percent of Medicare. Setting reimbursement at either of the recommended rates is contrary to the requirements of the Division to consider the economic indicators of health in establishing fee guidelines. It is unreasonable to suggest that the Division ignore ten years of inflationary pressures on hospitals in adopting these rules.

§134.404(f)(1)(A)-(B): A commenter recommends that an alternative payment adjustment factor of 175 percent of Medicare be established for hospital admissions that exceed 12 days. Commenter state that the average of twelve days represents more than 2.5 standard deviations above the mean length of stay for all workers' compensation cases and states that the proposed PAF will result in payments that are 32 percent of billed charges, 53 percent of current DWC allowed amounts and 77 percent of costs. Using a higher payment adjustment factor for extraordinarily long hospital stays will help to smooth out some of the payment inequities built into the Medicare outlier payment methodology.

Agency Response: The Division declines to make the change. The adopted rules require the use of the most current adopted and effective Medicare reimbursement methodologies, and reflect a reimbursement greater than

Medicare's reimbursement. Medicare DRGs, which adjust for severity and recognize the intensity of services for specific patients, will apply to services when these rules become effective. Establishing a different reimbursement methodology for cases with a length of stay greater than 12 days would realign the relative weights of the DRG methodology and be inconsistent with the prospective payment concepts of the Medicare system. Medicare reimbursement reflects average costs and length of stay, and in general is designed to cover costs and provide a profit for efficiently managed facilities. This concept extends to the outlier methodology. The 43 percent adjustment above Medicare reimbursement should provide some insulation for facilities in these cases. The payment adjustment factors provide further reimbursement to cover the costs of a lengthy stay.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For: Office of Injured Employee Counsel.

For, with changes: Individuals; Access MediQuip, LLC; Arkansas Best Corporation; Coventry Health Care; Hospital Corporation of America; Insurance Council of Texas; Medtronic, Inc.; Memorial Hermann; Property Casualty Insurers Association of America; Renaissance Healthcare Systems, Inc.; Scott and White; Service Lloyds Insurance Group; Texas Association of Business; Texas Hospital Association; Texas Mutual Insurance Company; and Zenith Insurance Company.

Neither For Nor Against: Broadspire and River Oaks Hospital.

6. STATUTORY AUTHORITY. The new rules are adopted under the Texas Labor Code §§408.021, 413.002, 413.007, 413.011, 413.012, 413.0511, 413.013, 413.014, 413.015, 413.016, 413.017, 413.019, 413.031; 402.0111, and 402.061.

Section 408.021 entitles injured employees to all health care reasonably required by the nature of the injury as and when needed. Section 413.002 requires the Division to monitor health care providers, insurance carriers and claimants to ensure compliance with rules adopted by the commissioner of workers' compensation, including fee guidelines. Section 413.007 sets out information to be maintained by the Division. Section 413.011 mandates that the Division by rule establish medical policies and guidelines. Section 413.012 directs the Division to review and revise the medical policies and fee guidelines at least every two years to reflect fair and reasonable fees. Section 413.0511 requires consultation with the Medical Advisor regarding the adoption of rules and policies to develop, maintain, and review guidelines. Section 413.013 requires the Division by rule to establish programs related to health care treatments and services for dispute resolution, monitoring, and review. Section 413.014 requires preauthorization by the insurance carrier for health care treatments and services. Section 413.015 requires insurance carriers to pay charges for medical services as provided in the statute and requires that the

Division ensure compliance with the medical policies and fee guidelines through audit and review. Section 413.016 provides for refund of payments made in violation of the medical policies and fee guidelines. Section 413.017 provides a presumption of reasonableness for medical services fees that are consistent with the medical policies and fee guidelines. Section 413.019 provides for payment of interest on delayed payments refunds or overpayments. Section 413.031 provides a procedure for medical dispute resolution. Section 402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.061 provides that the commissioner of workers' compensation has the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

7. TEXT.

Subchapter E. Health Facility Services

§134.403. Hospital Facility Fee Guideline – Outpatient.

(a) Applicability of this section is as follows.

(1) This section applies to medical services provided in an outpatient acute care hospital on or after March 1, 2008.

(2) This section does not apply to:

(A) professional medical services billed by a provider not employed by the hospital, except for a surgical implant provider as described in this section; or

(B) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

(b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise.

(1) "Acute care hospital" means a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma.

(2) "Implantable" means an object or device that is surgically:

(A) implanted,

(B) embedded,

(C) inserted,

(D) or otherwise applied, and

(E) related equipment necessary to operate, program and recharge the implantable.

(3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and

reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

(4) "Outpatient" means the patient is not admitted for inpatient or residential care. Outpatient medical services includes observation in an outpatient status provided the observation period complies with Medicare policies.

(5) "Surgical implant provider" means a person that arranges for the provision of implantable devices to a health care facility and that then seeks reimbursement for the implantable devices provided directly from an insurance carrier.

(c) A surgical implant provider is subject to Chapter 133 of this title and is considered a health care provider for purposes of this section and the sections in Chapter 133 of this title (relating to Benefits – Medical Benefits).

(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

(1) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division)

rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.

(2) Independent Review Organization decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(3) Whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later.

(e) Regardless of billed amount, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

(f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

(2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission.

(1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

(2) A carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding 133.307(d)(2)(B).

(3) Nothing in this rule precludes a health care facility or insurance carrier from utilizing a surgical implant provider to arrange for the provision of

implantable devices. Implantables provided by a surgical implant provider shall be reimbursed according to this subsection.

(h) For medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

(i) Notwithstanding Medicare payment policies, whenever Medicare requires a specific setting for a service, that restriction shall apply, unless an alternative setting and payment has been approved through the Division's preauthorization, concurrent review, or voluntary certification of health care process.

(j) A preauthorization request may be submitted for an alternative facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request. Copies of the agreement shall be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1).

(1) The agreement between the insurance carrier and the party that requested the alternative facility setting must be in writing, in clearly stated terms, and include:

(A) the reimbursement amount;

(B) a description of the services to be performed under the agreement;

(C) any other provisions of the agreement; and

(D) names of the entities, titles, and signatures of both parties, and names, titles, signatures with dates of the persons signing the agreement.

(2) An agreement for an alternative facility setting may be revised during or after preauthorization by written agreement of the insurance carrier and the party that requested the alternative facility setting.

(3) Upon request of the Division, all agreement information shall be submitted in the form and manner prescribed by the Division.

(k) If a court of competent jurisdiction holds that any provision of this section is inconsistent with any statutes of this state, are unconstitutional, or are invalid for any reason, the remaining provisions of this section shall remain in full effect.

§134.404. Hospital Facility Fee Guideline – Inpatient.

(a) Applicability of this section is as follows.

(1) This section applies to medical services provided in an inpatient acute care hospital with an admission date on or after March 1, 2008.

(2) For admission dates prior to March 1, 2008, the law and Division of Workers' Compensation (Division) rules in effect for those dates of service shall apply.

(3) This section does not apply to:

(A) professional medical services billed by a provider not employed by the hospital, except for a surgical implant provider as described in this section; or

(B) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

(b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise.

(1) "Acute care hospital" means a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma.

(2) "Implantable" means an object or device that is surgically:

(A) implanted,

(B) embedded,

(C) inserted,

(D) or otherwise applied, and

(E) related equipment necessary to operate, program and recharge the implantable.

(3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

(4) "Outlier payment amount" means the amount determined through use of the calculations described in subsection (f).

(5) "Surgical implant provider" means a person that arranges for the provision of implantable devices to a health care facility and that then seeks reimbursement for the implantable devices provided directly from an insurance carrier.

(c) A surgical implant provider is subject to Chapter 133 of this title and is considered a health care provider for purposes of this section and the sections in Chapter 133 of this title (relating to Benefits – Medical Benefits).

(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

(1) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.

(2) Independent Review Organization decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(3) Whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later.

(e) Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under

subsection (f), including any applicable outlier payment amounts and reimbursement for implantables.

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

(f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 143 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.

(2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission.

(1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

(2) A carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding §133.307(d)(2)(B) of this title.

(3) Nothing in this rule precludes a health care facility or insurance carrier from utilizing a surgical implant provider to arrange for the provision of implantable devices. Implantables provided by a surgical implant provider shall be reimbursed according to this subsection.

(h) A hospital that is classified by Medicare as a Sole Community Hospital, a Medicare Dependent Hospital, or a Rural Referral Center Hospital, shall initially be paid the amount calculated for such hospital in accordance with subsections (e) through (g) of this section. If the initial payment is less than the cost of the services in question, the hospital may request reconsideration in accordance with §133.250 of this title (relating to Reconsideration for Payment of Medical Bills) and present documentation of any amount it would have been paid under the Medicare regulations in effect when the services were performed. If such a showing is made, the hospital shall be paid the difference between the amount initially paid and the amount Medicare would have paid for the services as adjusted by the appropriate multiplier.

(i) Notwithstanding Medicare payment policies, whenever Medicare requires a specific setting for a service, that restriction shall apply, unless an alternative setting and payment has been approved through the Division's preauthorization, concurrent review, or voluntary certification of health care process.

(j) A preauthorization request may be submitted for an alternative facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request. Copies of the agreement shall be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1).

(1) The agreement between the insurance carrier and the party that requested the alternative facility setting must be in writing, in clearly stated terms, and include:

- (A) the reimbursement amount;
- (B) a description of the services to be performed under the agreement;
- (C) any other provisions of the agreement; and
- (D) names of the entities, titles and signatures of both parties, and names, titles, signatures with dates of the persons signing the agreement.

(2) An agreement for an alternative facility setting may be revised during or after preauthorization by written agreement of the insurance carrier and the party that requested the alternative facility setting.

(3) Upon request of the Division, the agreement information shall be submitted in the form and manner prescribed by the Division.

(k) If a court of competent jurisdiction holds that any provision of this section is inconsistent with any statutes of this state, are unconstitutional, or are invalid for any reason, the remaining provisions of this section shall remain in full effect.

CERTIFICATION. This agency certifies that the adopted sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on _____, 2007.

Norma Garcia
General Counsel
Texas Department of Insurance
Division of Workers' Compensation

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that new §§134.403 concerning Hospital Facility Fee Guideline – Outpatient and new §134.404 concerning Hospital Fee Facility Guideline – Inpatient are adopted.

TITLE 28. INSURANCE
Part 2. Texas Department of Insurance,
Division of Workers' Compensation
Chapter 134. Benefits-Guidelines for Medical Services, Charges, and Payments

Adopted Sections
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AND IT IS SO ORDERED.

ALBERT BETTS
COMMISSIONER OF WORKERS' COMPENSATION

ATTEST:

Norma Garcia
General Counsel

COMMISSIONER'S ORDER NO. _____